Clifton D. Bryant ❖ Dennis L. Peck *editors*

Encyclopedia of Death & the Human Experience

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Encyclopedia of Death & the Human Experience

edited by

Clifton D. Bryant ❖ Dennis L. Peck
Virginia Tech University *The University of Alabama*

SAGE
Los Angeles | London | New Delhi
Singapore | Washington DC

A SAGE Reference Publication

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For information:

SAGE Publications, Inc.
2455 Teller Road
Thousand Oaks, California 91320
E-mail: order@sagepub.com

SAGE Publications Ltd.
1 Oliver's Yard
55 City Road
London EC1Y 1SP
United Kingdom

SAGE Publications India Pvt. Ltd.
B 1/I 1 Mohan Cooperative Industrial Area
Mathura Road, New Delhi 110 044
India

SAGE Publications Asia-Pacific Pte. Ltd.
33 Pekin Street #02-01
Far East Square
Singapore 048763

Printed in the United States of America.

Library of Congress Cataloging-in-Publication Data

Encyclopedia of death and the human experience/editors, Clifton D. Bryant [and] Dennis L. Peck.
p. cm.
Includes bibliographical references and index.
ISBN 978-1-4129-5178-4 (cloth)
1. Death—Encyclopedias. I. Bryant, Clifton D., 1932- II. Peck, Dennis L.

HQ1073.E544 2009
306.903—dc22 2008052884

This book is printed on acid-free paper.

09 10 11 12 13 10 9 8 7 6 5 4 3 2 1

Publisher:	Rolf A. Janke
Assistant to the Publisher:	Michele Thompson
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Typesetter:	C&M Digitals (P) Ltd.
Proofreaders:	Theresa Kay, Sandy Livingston, Annie Lubinsky
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Cover Designer:	Candice Harman
Marketing Manager:	Amberlyn McKay

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Reader's Guide

The Reader's Guide for the *Encyclopedia of Death and the Human Experience* is provided to assist readers in locating entries on related topics. It organizes entries into 16 general topical categories: (1) Conceptualization of Death, Dying, and the Human Experience; (2) Arts, Media, and Popular Culture; (3) Causes of Death; (4) Coping With Loss and Grief; (5) Cross-Cultural Perspectives; (6) Developmental and Demographic Perspectives; (7) Disposition of the Deceased; (8) Funerals and Death-Related Activities; (9) Legal Matters; (10) Mass Death; (11) Process of Dying; (12) Religion; (13) Rituals, Ceremonies, and Celebrations; (14) Suicide, Euthanasia, and Homicide; (15) Theories and Concepts; and (16) Unworldly Entities and Events. From conceptualization of death and dying to the effects these phenomena have on those who survive, the more than 300 entries represent a range of insightful interdisciplinary topics crafted by international scholars and practitioners. Each topic is intended to provide the reader with insights into the phenomena that influence the social meanings of death and dying as these are created through the institutions that structure and organize the cultural artifacts, rituals, and ceremonies humans create and the symbols that influence the human experience.

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Death, Clinical Perspectives
Death, Humanistic Perspectives
Death, Philosophical Perspectives
Death, Psychological Perspectives
Death, Sociological Perspectives
Defining and Conceptualizing Death
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Disasters, Natural
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Food Poisoning and Contamination
HIV/AIDS
Karoshi
Medical Malpractice
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Neonatal Deaths
Prison Deaths
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Sudden Infant Death Syndrome (SIDS)
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About the Editors

Clifton D. Bryant is Professor Emeritus of Sociology at Virginia Tech University, where he served from 1972 to 2007. He was Department Head from 1972 to 1982. His teaching and research specialty areas include the sociology of death and dying, deviant behavior, military sociology, and the sociology of work and occupations. During his 47-year career, he enjoyed faculty status at six U.S. colleges and universities and two Southeast Asian universities. He also held Visiting Scientist status at three research institutes. He received his B.A. and M.A. degrees from the University of Mississippi, did advance graduate work at the University of North Carolina (Chapel Hill), and received his Ph.D. degree from Louisiana State University.

He served as President of the Southern Sociological Society (1978–1979). He was the recipient of the Southern Sociological Society's 2003 Distinguished Contributions to Teaching Award, and in 2007 he received its Distinguished Service Award. He was appointed to the Roll of Honor and received that award in 2009. The Roll of Honor Award is the highest award conferred on a member of the Southern Sociological Society and recognizes a career of distinguished intellectual contribution to sociology.

He was also president of the Mid-South Sociological Association (1981–1982). He was recipient of the Mid-South Sociological Association's Distinguished Career Award in 1991 and received its Distinguished Book Award in 2001 and in 2004.

His other reference works include *21st Century Sociology: A Reference Handbook* (coedited with Dennis Peck, 2007), the *Handbook of Death & Dying* (2003), and the *Encyclopedia of Criminology and Deviant Behavior* (2001). Beyond these reference works, he has authored or edited 11 other books and published articles in many professional journals.

Dennis L. Peck is Professor Emeritus of Sociology in the College of Arts and Sciences at The University of Alabama. He has authored and coauthored over 50 articles published in refereed journals and over 40 books, monographs, and book chapters. In addition to contributing to the learned literature throughout his career, during the present decade Dr. Peck has served as lead editor in chief of *21st Century Sociology: A Reference Handbook* (2007) and was instrumental in the creation of the four-volume *Encyclopedia of Criminology and Deviant Behavior* (2001), serving as coeditor of Volume 2 and associate editor for the entire project. In addition, Dr. Peck was a contributor to, and associate editor for, the *Handbook of Death & Dying* (2003), a publication that was recognized by the American Library Association as an outstanding reference of the year.

In addition to his interdisciplinary contributions in the general areas of deviant behavior, criminology, and death and dying, Dr. Peck was editor of *Sociological Inquiry*, the International Honor Society Journal of Alpha Kappa Delta, for 6 years. He has or currently serves on several editorial boards and in numerous professional association positions, including President of the Mid-South Sociological Association and the Alabama-Mississippi Sociological Association. While on leave from The University of Alabama on two occasions, he served in Washington, D.C., as a Senior Analyst with the Department of Housing and Urban Developments and with the Department of Education.

Dr. Peck's teaching and research interests are in the general areas of demography, the sociology of law, and deviant behavior. He has authored and edited several books, chapters, and journal articles in the areas of suicide, public health, psychiatric law, democracy, toxic waste disposal, life

without parole, human sexuality, urban development programming, post-traumatic stress disorder, program evaluation, divorce, social policy, and civility.

He was awarded B.S. and M.S. degrees from, and is recognized as Distinguished Alumnus of, the University of Wisconsin–Milwaukee. Dr. Peck earned a Ph.D. from Washington State University.

About the Editorial Board

Associate Editors

Kelly A. Joyce received her B.A. in anthropology from Brown University and her Ph.D. in sociology from Boston College. She is Associate Professor of Sociology at the College of William & Mary. Dr. Joyce's research focuses on the use of visualization technologies in medical practice. She is the author of *Magnetic Appeal: MRI and the Myth of Transparency*, has published articles on visualization in medicine in the journals *Science as Culture* and *Social Studies of Science*, and has a chapter in the edited volume *Biomedicalization: Technoscience, Health and Illness in the United States* (forthcoming). Dr. Joyce also investigates the intersections between health, aging, science, and technology. She has published articles in this area and is a coeditor of the 16th Sociology of Health and Illness monograph, titled *Technogenarians: Studying Health and Illness Through an Aging, Science, and Technology Lens*. Her current research examines autoimmune disorders, particularly lupus and Crohn's disease. Dr. Joyce is interested in the sociology of medical knowledge. Her research on autoimmune disorders considers medical constructions of the immune system and the gastrointestinal tract.

Vicki L. Lamb is Associate Professor of Sociology at North Carolina Central University and Senior Research Scientist in the Center for Population Health and Aging at Duke University. She received her M.S. in sociology from Virginia Tech, her Ph.D. in sociology from Duke University, and completed a postdoctoral fellowship at the Center for Demographic Studies at Duke University. She does research on the demography of health, disability, and the life course, and studies active life expectancy, successful aging, Medicare costs, elderly disability, and trends in long-term care of the elderly. Dr. Lamb is also interested in statistical methodology. Some of her recent journal publications appear in the *Proceedings of the National Academy of Science USA, Population and Development Review, Social Indicators Research, Journal of Health and Aging, Journal of Ambulatory Care Management,* and *Health Services Research*. She has contributed to numerous books and handbooks, including the *Handbook of Death & Dying* (2003), *Key Indicators of Child and Youth Well-Being,* the *Encyclopedia of Public Health, African American Family Life, Methods and Materials of Demography,* and *Determining Health Expectancies*. Dr. Lamb teaches graduate and undergraduate courses in social gerontology, medical sociology, demography, social statistics, and survey research methods.

Jon K. Reid is Professor of Psychology and Counseling at Southeastern Oklahoma State University, where he served as Chair of the Department of Behavioral Sciences for 6 years. He regularly teaches courses on human development, human sexuality, death and dying, and grief counseling. As a licensed professional counselor (Texas) for over 20 years, Dr. Reid has provided counseling in a variety of settings, including leading grief support groups in hospitals, churches, and schools. For 6 years, he served as a grief consultant for a children's grief camp held annually for 1 week in the summer. A member of the Association for Death Education and Counseling (ADEC) since 1995, Dr. Reid has served on a number of ADEC committees as well as on the ADEC Board of Directors. He has published articles in the journals *Death Studies, Illness, Crisis, and Loss* and the *Journal of Personal and Interpersonal Loss,* and a chapter in the *Handbook of Death & Dying* (2003). In addition, he has earned certification as a Fellow in Thanatology through ADEC.

Hikaru Suzuki is a social anthropologist whose research focuses on death and the funerary industry in Japan. Previously at Singapore Management University, Dr. Suzuki received her Ph.D. from Harvard and her M.B.A. from the University of

Wisconsin–Madison. Her book, *The Price of Death: The Funeral Industry in Contemporary Japan,* was based on her fieldwork with a funeral company in Kita-Kyushu, Japan. During this research placement, she worked as an employee, performing, on average, two wakes and one funeral per day. Dr. Hikaru participated in all elements of the funerary process, from picking up the deceased from the hospital; cleansing, bathing, and dressing the deceased; and sending off the deceased to the crematory, as well as arranging wakes, funerals, and memorial services. Among her other major publications are "McFunerals: The Transition of Japanese Funerary Services" (*Asian Anthropology*) and "Japanese Death Rituals in Transit: From Household Ancestors to Beloved Antecedents" (*Journal of Contemporary Religion*). She was recently a plenary speaker at the 8th International Conference on Death, Dying, and Disposal in Bath, United Kingdom, where she presented her paper "Japanese Funerals in the Global Age." Dr. Hikaru is currently editing *Death and Dying in Contemporary Japan*, which is planned for publication in 2010.

Michael R. Taylor is Associate Professor in the Department of Philosophy and an affiliated faculty member of the School of International Studies at Oklahoma State University. He teaches courses in social and political philosophy, applied ethics, philosophy of education, and perspectives on death and dying, as well as several nontraditional courses on ethics and globalization. His research focuses on social and ethical problems of international scope and is oriented toward a collaborative and multidisciplinary approach. Among his recent publications are *Pragmatism, Education, and Children: International Philosophical Perspectives* (coedited with Helmut Schreier and Paulo Ghiraldelli Jr., 2008), and "Illegal Immigration and Moral Obligation" in *Public Affairs Quarterly* (January 2008).

Lee Garth Vigilant received his Ph.D. from Boston College in 2001 and is Associate Professor of Sociology at Minnesota State University Moorhead. He teaches in the areas of classical sociological theory, qualitative methods for social research, contemporary sociological theory, social thanatology, health and illness, and social problems. He is a past recipient of the Donald J. White Teaching Excellence Award for Sociology at Boston College (2000) and the TCU Senate Professor of the Year Award from Tufts University (2001). Dr. Vigilant's past research focuses on the meaning of recovery in addiction subcultures. His peer-reviewed publications appear in the journals *Sociological Spectrum*, *Deviant Behavior*, and *Humanity and Society*. He is author of several sociological essays, encyclopedia entries, and book chapters. He is coeditor of the books *Social Problems: Readings With Four Questions* and *The Meaning of Sociology: A Reader* (9th edition). Dr. Vigilant is currently studying the social roles of fathers in home-schooling families.

Advisory Board Members

Andrew Bernstein is Associate Professor in the History Department and East Asian Studies Program at Lewis and Clark College, Portland, Oregon. He received his B.A. from Amherst College in 1990 and his Ph.D. from Columbia University in 1999. His research focuses primarily on modern Japan and is driven by a fundamental question: How do people build and maintain connections to the past in the midst of radical change? In *Modern Passings: Death Rites, Politics, and Social Change in Imperial Japan* (2006), he addresses this abstract question by examining how Japanese cope with a specific but universal question: What do we do with the dead? Dealing with this ever-present problem generally meant relying on ancestral solutions, which took the form of death rites that had developed over the centuries to build continuity in the face of loss. At present Dr. Bernstein is writing *Fuji: A Mountain in the Making*, a comprehensive "biography" of Mt. Fuji that explores the dynamic and contradiction-filled relationship between the volcano as a physical product of nonhuman forces and a cultural icon shaped by all-too-human hopes and desires.

Douglas James Davies is Professor in the Study of Religion at the Department of Theology and Religion, Durham University, United Kingdom, and Director of that university's Centre for Death and Life Studies. Previously Dr. Davies was Professor of Religious Studies at Nottingham University, where he also wrote a doctoral thesis on salvation in relation to the sociology of knowledge. He was educated at the Lewis School, Pengam, in South Wales, at Durham University's Departments of Anthropology and of Theology, and at the Institute of Social Anthropology at Oxford University. He has taught courses on death, ritual, and belief for many years at Nottingham University and Durham University. He is currently directing funded research

projects both on woodland burial and on emotion and identity in religious communities funded by the UK Arts and Humanities Research Council, as well as a major interdisciplinary project on cremation in Scotland funded by the Leverhulme Trust. Among his many publications on death are the coedited *Encyclopedia of Cremation* (2005); *A Brief History of Death* (2004); *Death, Ritual and Belief* (2002); *Health, Morality and Sacrifice: The Sociology of Disasters* (2002); *Death, Ritual and Belief, The Rhetoric of Funerary Rites* (1997); and *Cremation Today and Tomorrow* (1990).

Lynne Ann DeSpelder is an author, counselor, and Professor of Psychology at Cabrillo College in Aptos, California, and holds a Fellow in Thanatology from the Association for Death Education and Counseling (ADEC). Her writing in the field includes *The Last Dance: Encountering Death and Dying* (8th edition); *A Journey Through The Last Dance: Activities and Resources*; and most recently, "Culture, Socialization, and Death Education" in *Handbook of Thanatology*. She was corecipient of ADEC's Death Education Award. Lynne conducts trainings and speaks about death, dying, and bereavement both nationally and internationally, recently in Italy, England, and Japan. She is a member of ADEC, the International Work Group in Death, Dying and Bereavement, and is on the international editorial board of *Mortality.*

Kenneth J. Doka is a Professor of Gerontology at the College of New Rochelle, an ordained Lutheran minister, and Senior Consultant to the Hospice Foundation of America. Dr. Doka's books include *Death, Dying and Bereavement: Major Themes in Health and Social Welfare; Pain Management at the End-of-Life: Bridging the Gap Between Knowledge and Practice; Men Don't Cry, Women Do: Transcending Gender Stereotypes of Grief; Disenfranchised Grief: Recognizing Hidden Sorrow; Living With Life Threatening Illness; Children Mourning, Mourning Children; Death and Spirituality; Caregiving and Loss: Family Needs, Professional Responses; AIDS, Fear and Society; Aging and Developmental Disabilities; and Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice*; and several *Living With Grief* titles. In addition, he has published over 100 articles and book chapters. Dr. Doka is currently editor of *Omega: The Journal of Death and Dying* and *Journeys: A Newsletter for the Bereaved*. He served as President of the Association for Death Education and Counseling and on the Board of Directors of the International Work Group on Dying, Death and Bereavement. In addition he has served as a consultant to medical, nursing, funeral service, and hospice organizations as well as businesses and educational and social service agencies.

J. C. Upshaw Downs has been employed as a medical examiner since 1989 and was Alabama's State Forensics Director and Chief Medical Examiner from 1998 to 2002. He has served as consultant to the Federal Bureau of Investigation (FBI) Behavioral Science Unit in Quantico, Virginia, and has authored four chapters in their manual *Managing Death Investigation*. Dr. Downs is the primary author of the FBI's acclaimed *Forensic Investigator's Trauma Atlas*. He has authored several books and chapters in the field of forensic pathology and child abuse. He has testified in state and federal courts, as well as before committees of the U.S. Senate and House of Representatives. He completed two terms on the Board of Directors of the National Association of Medical Examiners. He is on the Board of Advisors for the Law Enforcement Innovation Center at the University of Tennessee and the Board of Directors of the National Forensic Science Technology Center. Dr. Downs graduated from the University of Georgia. He received his M.D. degree and his residency training in anatomic and clinical pathology, and his fellowship in forensic pathology from the Medical University of South Carolina (Charleston). He is board certified in anatomic, clinical, and forensic pathology.

Michael C. Kearl received a B.A. in sociology from Dartmouth College and a Ph.D. in sociology from Stanford University. Dr. Kearl is Professor of Sociology at Trinity University, where he has taught for more than 30 years. In addition to the sociology and anthropology of death and dying, Dr. Kearl's primary areas of teaching and research include social gerontology, social psychology, the sociology of time, and the sociology of knowledge. Author of *Endings: A Sociology of Death & Dying* and webmaster of a website on death studies, his publications investigate such subjects as the political uses of the dead in civil religion, the rise of abortion as a political litmus test, the growing roles of the dead in popular culture, impacts of increasing cremation rates on the American death ethos, growing old in a death-denying culture, the ideological orientations of hospice workers, and American immortalism and its battles against extinction. During the 1980s he

served as a public member of the Texas State Board of Morticians and was involved in passing extensive consumer-oriented legislation. Dr. Kearl is currently writing *The Times of Our Lives,* a collection of essays that range from the prolongation of adolescence and its impacts on other life cycle stages to the implications of cultural golden years.

Michael R. Leming is Professor of Sociology at St. Olaf College in Minnesota. He holds degrees from Westmont College (B.A.), Marquette University (M.A.), and the University of Utah (Ph.D.). He has completed additional graduate study at the University of California, Santa Barbara. He is the founder and former director of the St. Olaf College Social Research Center and is a former member of the Board of Directors of the Minnesota Coalition of Terminal Care. He helped establish two hospice programs and continues to give lectures to hospice programs and caregivers for the dying and the bereaved and is involved in the education of future thanatology workers. He has served as a steering committee member of the Northfield AIDS Response and as a hospice educator, volunteer, and grief counselor. He is the author of numerous articles on thanatology and family issues and has taught courses on death and dying for over 30 years. He is the coauthor of *Understanding Dying, Death, and Bereavement* and *Understanding Families: Diversity, Continuity, and Change*. He is also the coeditor of *The Sociological Perspective: A Value-Committed Introduction*.

John L. McIntosh is Associate Vice Chancellor for Academic Affairs and Professor of Psychology at Indiana University–South Bend. Dr. McIntosh is the author, coauthor, or coeditor of six books on the topic of suicide (including *Elder Suicide* and *Suicide and Its Aftermath*) and has contributed chapters to several books and articles to many professional journals. He serves on the editorial boards of *Suicide & Life-Threatening Behavior* (associate editor); *Gerontology and Geriatrics Education; Crisis: The Journal of Crisis Intervention and Suicide Prevention*; and *Surviving Suicide*. He is a member of the Editorial Advisory Board of *Advancing Suicide Prevention* magazine. Dr. McIntosh is on the national Advisory Council of the Yellow Ribbon Suicide Prevention Program. He is a past president of the American Association of Suicidology, a past member of the American Association of Suicidology Board of Directors, and has served as Secretary of the AAS Board of Directors. His primary research areas are elder suicide, epidemiology of suicide, and survivors of suicide.

Robert A. Neimeyer is Professor and Director of Psychotherapy Research in the Department of Psychology, University of Memphis, where he also maintains an active clinical practice. Since having completed his doctoral training at the University of Nebraska in 1982, he has conducted extensive research on the topics of death, grief, loss, and suicide intervention. Dr. Neimeyer has authored 20 books, including *Meaning Reconstruction and the Experience of Loss; Lessons of Loss: A Guide to Coping;* and *Rainbow in the Stone,* a book of contemporary poetry. The author of over 300 articles and book chapters, he is currently working to advance a more adequate theory of grieving as a meaning-making process. Dr. Neimeyer is the editor of *Death Studies* and the *Journal of Constructivist Psychology,* and he is a past president of the Association for Death Education and Counseling. He was appointed to the American Psychological Association's Task Force on End-of-Life Issues, where he helped implement a research and practice agenda for psychology in this critical area.

John B. Williamson received a B.S. degree from the Massachusetts Institute of Technology and was awarded a Ph.D. in social psychology from Harvard University. Dr. Williamson is currently Professor of Sociology at Boston College, where he has taught a large undergraduate course on death and dying for more than 20 years. He has published 16 books and over 120 journal articles and book chapters. In the area of death studies he has published articles and book chapters on euthanasia, suicide, homicide, hospice, body recycling, death anxiety, symbolic immortality, terrorism, accidental deaths, maternal mortality, child mortality, and infant mortality. Among his coauthored and coedited books are *Death: Current Perspectives*; *The Generational Equity Debate; The Senior Rights Movement; Age, Class Politics and the Welfare State; Old Age Security in Comparative Perspective;* and *The Politics of Aging*. He is currently Chair of the Social Research, Policy, and Practice section and a vice president of the Gerontological Society of America. Dr. Williamson is affiliated with the Center for Retirement Research and with the Center for Work and Aging, both at Boston College. The focus of much of his current research is on retirement and the comparative international study of social security systems.

Contributors

William C. Allen
Temple University

Marga Altena
Nijmegen University

Sophia Anong
Virginia Tech University

Patrick Ashwood
Hawkeye Community College

Nicole Back
Franciscan Village

Carol A. Bailey
Virginia Tech University

David Balk
City University of New York at Brooklyn College

Janet Balk
Barton County Community College

Lesley Bannatyne
Independent Scholar/Writer

Raymond Barfield
Duke University, School of Medicine

Ronald K. Barrett
Loyola Marymount University

Margaret Pabst Battin
University of Utah

Ann Korologos Bazzarone
Independent Scholar

Renée L. Beard
University of Chicago

Philip Beh
University of Hong Kong

Regina Belkin
Private Practitioner

Nachman Ben-Yehuda
Hebrew University

Frances P. Bernat
Arizona State University

Andrew Bernstein
Lewis and Clark College

Jan Bleyen
Katholieke Universiteit Leuven

Marjie Bloy
Beijing Language and Culture University (Retired)

Sophie Bolt
Radboud University Nijmegen

Pauline Boss
University of Minnesota

Sarah Brabant
University of Louisiana at Lafayette (Retired)

Michael Bracy
Oklahoma State University

James Brandman
Northwestern University Feinberg School of Medicine

Peter Branney
Leeds Metropolitan University

Andrea Malkin Brenner
American University

Emma Brodzinski
Royal Holloway, University of London

Heidi F. Browne
Virginia Tech University

Clifton D. Bryant
Virginia Tech University (Professor Emeritus)

Robert Buckman
University of Toronto

Randy Cagle
Minnesota State University Moorhead

James Cain
Oklahoma State University

Bruce B. Campbell
College of William & Mary

Kathleen Campbell
U.S. Army Military Academy

Deborah Carr
Rutgers University and University of Wisconsin

Cecilia Lai Wan Chan
University of Hong Kong

Cypress W. Chang
National Taipei College of Nursing

Amy Y. M. Chow
University of Hong Kong

Elise Madeleine Ciregna
University of Delaware

Jeffrey Michael Clair
University of Alabama at Birmingham

Eugenia Conde
Texas A&M University

Charles A. Corr
Hospice Institute of the Florida Suncoast

Rachel Traut Cortes
Texas A&M University

Brittney L. Coscomb
Temple University

Gerry R. Cox
University of Wisconsin–La Crosse

Sarah Dauncey
University of Warwick

Betty Davies
University of California, San Francisco

Christie Davies
University of Reading

Douglas J. Davies
Durham University

Grégory Delaplace
University of Cambridge

Michael Robert Dennis
Emporia University

Bethany S. DeSalvo
Texas A&M University

Regis A. de Silva
Harvard University

Lynne Ann DeSpelder
Cabrillo College

Anna Maria Destro
Eastern Piedmont University Medical School

George E. Dickenson
College of Charleston

Kenneth J. Doka
College of New Rochelle

J. C. Upshaw Downs
Georgia State Regional Medical Examiner's Office

Cristina Dumitru-Lahaye
University Paris Descartes and University of Bucharest

Jerry Durham
Allen College

Keith F. Durkin
Ohio Northern University

James W. Ellor
Baylor University

Paul Elvig
International Cemetery, Cremation & Funeral Association

Charles F. Emmons
Gettysburg College

Mario Erasmo
University of Georgia

Eric J. Ettema
Vrije Universiteit Medical Centre

Lisa M. Farley
Sage Colleges

Christopher J. Ferguson
Texas A&M International University

Abbott L. Ferriss
Emory University

Amy C. Finnegan
Boston College

Patti J. Fisher
Virginia Tech University

Phil Fitzsimmons
University of Wollongong

Mónica J. Giedelmann Reyes
Universidad Pontificia Bolivariana

Richard B. Gilbert
Mercy College

Herbert Glaser
Aurora Casket

Erik D. Gooding
Minnesota State University Moorhead

Emma-Jayne Graham
Cardiff University

Susan-Mary Grant
Newcastle University

James W. Green
University of Washington

Howard Gruetzner
Alzheimer Association

Harry Hamilton
University of Alabama at Birmingham

Robert O. Hansson
University of Tulsa

Helen Harris
Baylor University

Graham Harvey
Open University

James Hawdon
Virginia Tech University

Celia Ray Hayhoe
Virginia Cooperative Extension

Bert Hayslip Jr.
University of North Texas

Meike Heessels
Radboud University Nijmegen

Marty H. Heitz
Oklahoma State University

Bradley R. Hertel
Virginia Tech University

Janice Miner Holden
University of North Texas

Glennys Howarth
University of Bath

Richard T. Hull
State University of New York at Buffalo (Retired)

Corinne G. Husten
Partnership for Prevention

Keith Jacobi
The University of Alabama

Claude Javeau
Université Libre de Bruxelles

Emilie Jaworski
University Paris Descartes

Christopher J. Johnson
University of Louisiana at Monroe

Ronald E. Jones
Alabama State Department of Corrections (Retired)

Kelly A. Joyce
College of William & Mary

Jack Kamerman
Kean University

Asa Kasher
Tel Aviv University

Robert Kastenbaum
Arizona State University

Michael Kearl
Trinity University

Margareta Kern
Independent Photographer/ Artist

Kriss A. Kevorkian
University of Wisconsin–Eau Claire

John E. King
University of Arkansas

Daniel J. Klenow
North Dakota State University

James Knapp
Southeastern Oklahoma State University

Sawa Kurotani
University of Redlands

Vicki L. Lamb
North Carolina Central University

Lorraine Y. Landry
Oklahoma State University

Edie Marie Lanphar
San Roque School

Kenzie Latham
University of Florida

Irene E. Leech
Virginia Tech University

Michael R. Leming
St. Olaf College

David Lester
Richard Stockton College of New Jersey

Daniel Leviton
University of Maryland (Retired)

Yu-chan Li
National Taipei College of Nursing

J. Robert Lilly
Northern Kentucky University

Jack LoCicero
Madonna University

Patricia Lysaght
University College Dublin

Nora Machado
University of Gothenburg

Vicky M. MacLean
Middle Tennessee State University

Anna Madill
University of Leeds

Charles Maynard
University of Washington

Ryan McDonald
College of William & Mary

John L. McIntosh
Indiana University South Bend

Barbra McKenzie
University of Wollongong

Stephen J. McNamee
University of North Carolina Wilmington

Anne K. Mellor
University of California, Los Angeles

Gregg D. Merksamer
Professional Car Society

Paul Metzler
Director of Community & Program Services

Jon'a F. Meyer
Rutgers University

Leslie D. Meyer
Texas A&M University

Robert K. Miller
University of North Carolina Wilmington

Ted R. Miller
Pacific Institute for Research and Evaluation

Tony Milligan
University of Aberdeen

Jason Milne
Longwood University

Penelope J. Moore
Iona College

Brenda Moretta Guerrero
Our Lady of the Lake University

Eve L. Mullen
Emory University

Robert A. Neimeyer
University of Memphis

Kristie Niemeier
University of Kentucky

Nik Suryani Nik Abd Rahman
International Islamic University Malaysia

Illene C. Noppe
University of Wisconsin–Green Bay

Lauren A. O'Brien
University of Georgia

Emiko Ohnuki-Tierney
University of Wisconsin

Linda W. Olivet
The University of Alabama (Emeritus Dean of Nursing)

Richard W. Oram
University of Texas at Austin

Ann M. Palkovich
George Mason University

Chang-Won Park
Durham University

David Patterson
University of Memphis

Dennis L. Peck
The University of Alabama (Professor Emeritus)

Chuck W. Peek
University of Florida

Janneke Peelen
Radboud University Nijmegen

Sami Pihlström
University of Jyväskylä

Maurizio Pompili
Sant'Andrea Hospital/ Sapienza University of Rome

Dudley L. Poston Jr.
Texas A&M University

Thomas Quartier
University of Nijmegen

Haniza Rais
International Islamic University Malaysia

Lillian Range
Our Lady of Holy Cross College

Najwa Raouda
Oklahoma State University

Mark D. Reed
Georgia State University

Jon K. Reid
Southeastern Oklahoma State University

Eric Reitan
Oklahoma State University

Abigail B. Reiter
University of North Carolina Wilmington

Gary T. Reker
Trent University

Mary Elizabeth Richards
Brunel University

Jessica M. Richmond
University of Akron

Ferris J. Ritchey
University of Alabama at Birmingham

Karen A. Roberto
Virginia Tech University

Daniel A. Roberts
Temple Emanu El

Deborah Mitchell Robinson
Valdosta State University

J. Earl Rogers
Independent Scholar/ Writer

Paul M. Roman
University of Georgia

Bronna D. Romanoff
Sage Colleges

Susan Roos
Roos and Associates

Lori A. Roscoe
University of South Florida

Paul C. Rosenblatt
University of Minnesota

Virginia Rothwell
Virginia Tech University

Jeffrey Burton Russell
University of California, Santa Barbara

Terri Sabatos
U.S. Army Military Academy

Melissa Sandefur
Middle Tennessee State University

George Sanders
Oakland University

Lars Sandman
Gothenburg University and University College of Borås

Duncan Sayer
University of Bath

Donna L. Schuurman
Dougy Center for Grieving Children & Families

Gillian Scott
University of York

Steven J. Seiler
University of Tennessee

Kenneth W. Sewell
University of North Texas

Andrew Sherwood
University of Pittsburgh at Johnstown

Edwin S. Shneidman
University of California, Los Angeles (Professor Emeritus)

Donald J. Shoemaker
Virginia Tech University

Jacqueline Simpson
The Folklore Society, London

Sangeeta Singg
Angelo State University

Caitlin E. Slodden
Brandeis University

Caroline C. Smith
Sage Colleges

Harold Ivan Smith
American Academy of Bereavement

Carla Sofka
Siena College

Steven Stack
Wayne State University

Silke Steidinger
Inform

Irene Stengs
Meertens Institute

Robert G. Stevenson
Mercy College

David J. Stewart
East Carolina University

Jenny Streit-Horn
University of North Texas

Albert Lee Strickland
Pacific Publishing Services

Chia-shing Su
Won-Ann Life Corp.

Hikaru Suzuki
Singapore Management University

Kay Talbot
Chapman University

Orit Taubman–Ben-Ari
Bar-Ilan University

Michael R. Taylor
Oklahoma State University

Kim S. Theriault
Dominican University

Laurence Thomas
Syracuse University

Anke Tonnaer
Radboud University Nijmegen

Tom Tseng
Institute of Life and Death Education and Counseling

Karma Lekshe Tsomo
University of San Diego

Christine Valentine
University of Bath

Eric Venbrux
Radboud University Nijmegen

Bérangère Véron
Observatoire Sociologique du Changement

Thomas J. Vesper
Law Firm of Westmoreland, Vesper & Quattrone

Lee Garth Vigilant
Minnesota State University Moorhead

Christopher P. Vogt
St. John's University

Paul Voninski
State University of New York Oswego

Tony Walter
University of Bath

Charles Walton
Lynchburg College

Melissa L. Ward
University of North Texas

Jason Adam Wasserman
Texas Tech University

Diane M. Watts-Roy
Boston College

Gary R. Webb
Oklahoma State University

J. Mack Welford
Roanoke College

James L. Werth Jr.
Radford University

Joyce E. Williams
Texas Woman's University

Holly L. Wilson
University of Louisiana at Monroe

Joanna Wojtkowiak
Radboud University

William R. Wood
California State University, Fullerton

Kate Woodthorpe
Open University

Elena Yakunina
University of Akron

Malgorzata Zawila
Jagiellonian University

Preface

The essence of interdisciplinary thanatological study of death-related behavior is characterized in this two-volume *Encyclopedia of Death and the Human Experience*. Death and dying and death-related behavior involves the causes of death and the nature of the actions and emotions surrounding death among the living. The content of this comprehensive library reference is inclusive of the complex cultural beliefs and traditions and the institutionalized social rituals that surround dying and death as well as the array of emotional responses relating to bereavement, grieving, and mourning.

The *Encyclopedia of Death and the Human Experience* represents the theoretical and the practical. It is a compendium statement of the interdisciplinary, scholarly nature of death and dying research and study, as well as the practical applications of the knowledge generated by professional and lay persons whose career paths have been responsive to and reflective of the human experience. Moreover, the approximately 330 entries represent an array of approaches that portray the natural order of the life cycle as well as the socially constructed cultural artifacts created as humans attempt to deal with life experiences involving the anticipation of death, the process of dying, rituals in which the legacy of the deceased are celebrated, and the meaningful symbolic enhancement of a society through its cultural entities.

The content of this two-volume set is historical, it is contemporary, and it is futuristic. The entry titles result from the combined effort of experienced Sage Publications professionals with contributions by the editors. Based on this effort we are privileged to include in this manuscript the contributions provided by several generations of scholars who are, in turn, responsible for the initial and then extensive subsequent interest in death and dying research. Their efforts were not always appreciated within the previous mainstream of scholarly research, but the commitment of these individuals, many of whom contributed to this encyclopedia, stands as testimony to the creation of new pathways of knowledge. Moreover, their intense interest resulted, ultimately, in the creation of academic courses on death and dying and then the creation of programs that are, in large part, responsible for all the entries presented in this two-volume set.

The international contributors bring important interdisciplinary and cross-cultural perspectives to the encyclopedia. The many fine international scholars and practitioners are from Africa, Asia (China, Hong Kong, and Singapore), and Australia; North and South Americas; and many European countries, including France, Great Britain, Iceland, Ireland, Italy, and Spain. Included among the authors are research scholars, health practitioners, and counselors of many areas of expertise, and members of the arts. These individuals represent, or are engaged in, the practice of anthropology, the clergy, counseling, economics, education, English, evaluation research, family studies, fashion advisors, history, law, medical researchers and clinicians, museum directors, nursing, organization directors, political science, psychiatry, psychology, religious studies, sociology, and social work. This experienced group of talented contributors offers important insight into the process of dying and the phenomenon of death. Along with the special focus on the cultural artifacts and social institutions and practices that constitute the human experience, the combination focus on the human condition and experience makes this an extraordinary reference encyclopedia.

Project Description

Interest in the varied dimensions of death and dying has led to the development of death studies that

move beyond medical research to include behavioral science disciplines and practitioner-oriented fields. As a result of this interdisciplinary interest, the literature in the field of death and the human experience studies has dramatically increased during the past 20 years. Death-related terms and concepts that encompass global beliefs and traditions, death denial, and social movements as well as interdisciplinary and practitioner-oriented perspectives on death now hold important ecological, family, economic, medical, legal, religious, and global social-psychological consequences. Examples include death-related terms and concepts such as angel makers, appropriate death, Chinese death taboos, death anxiety, the postself, body farms, dance of death (*danse macabre*), equivocal death, end-of-life decision making, near-death experiences, cemeteries, ghost photography, halo nurses, memorials, viatical settlements, second burial, suicide, medical mistakes, advance directives, caregiver stress, SIDS, cryonics, cyberfunerals, global religious beliefs and traditions, and death denial. As a result, many terms and phrases are now part of common social discourse and media reporting. But the lexicon relating to dying, death, and the emotions, activities, and policy relating to the human experience is expansive, thus lending itself to the need to establish consistency in vocabulary of death meanings. The *Encyclopedia of Death and the Human Experience* does so, and this two-volume library reference is enriched through important multidisciplinary contributions and perspectives as it arranges, organizes, defines, and clarifies a comprehensive listing of approximately 330 death-related issues, concepts, perspectives, and theories for use by students and scholars, while facilitating a more refined and sensitive understanding of the field for an increasingly interested public.

Development of the Project

The initial list of entries was compiled through a search of learned journals and topic-specific textbooks. Such searches were useful for identifying the classic concepts, theories, and terms, but suggestions that identify emerging concepts and work currently being conducted came from an even more valuable resource, namely the members of the encyclopedia's editorial board and from scholars and practitioners who recommended prospective entries be considered even after a final list of topics had been compiled. Thus, the richness of the total list of entries results from the interest and input of the many individuals who have so freely given to this project.

Authorship of the entries was developed in a similar manner. Recognized contributors to the area of thanatology study were requested to offer their considerable insight and talent by crafting entries. In turn, the authorship list was expanded as networks were identified and specific authors were invited to participate. Ultimately, interest in this project was to take on a life of its own as the project became international in scope.

The Reader's Guide

Developed around 16 categories, the Reader's Guide includes approximately 330 entries, many of which address traditional death- and dying-related topics. But, in addition, a special focus on the human experience enhances the overall substance of this work. This important focus on the human condition blends an interesting array of new topics with traditional entries to create a unique dimension to the study of death and dying.

Conceptualization of Death, Dying, and the Human Experience: This introductory category offers the definition and conceptualization of death and the human experience from the interdisciplinary perspectives that are representative of the *Encyclopedia of Death and the Human Experience*. These areas include the humanities, social sciences, religious perspectives, medical sciences, and legal approaches to understanding the increasingly complex issues involved in death and dying and for those who must continue to function in the aftermath of the death of a loved one. Special focus is accorded the secular scientific approach with topics that include forensic anthropology, forensic science, and the process leading to the medicalization of death and dying.

Arts, Media, and Popular Culture: This category consists of the kinds of entries that lend insightful discussion of the display and depictions of death in art, literature, photography, sculpture, architecture, wax museums, and museums of death. A more contemporary characterization of death is noted in entries that address popular culture movies and video games with a death theme.

Causes of Death: This category consists of entries that address issues of social and historical significance as well as important contemporary policy implications. The leading worldwide causes of death are prominently represented. This section also include entries pertaining to capital punishment and prison deaths, drug use and abuse, man-made and natural disasters, spontaneous combustion, subintentional death, domestic and international terrorism, and tobacco use.

Coping With Loss and Grief: Special attention is cast toward the living as they try to cope with issues attendant to dying and death. Included in this category is historical coverage of grief, bereavement, and mourning, each of which is found in abundance in the contemporary experience. Ranging from entries titled Denial of Death and Death Anxiety to those of Gold Star Mothers, Instrumental Grieving: Gender Differences, the Postself, and Widows and Widowers, this section includes entries that address the individual micro-level and macro-level human experiences and the consequences relating to dying and death.

Cross-Cultural Perspectives: This is a category of exceptional entries that lends credence to the ancient beliefs, traditions, and practices and perspectives toward dying and death, and those among the indigenous tribes of Australia and North America. A compendium statement of the social, cultural, and moral views is found within *The Tibetan Book of Living and Dying* entry. Included also is a cross-cultural perspective of the death care industry, the social functions of death, and Chinese death taboos. Such entries add a special tone to these international orientations.

Developmental and Demographic Perspectives: This category is represented by entries that cover the stages of life and the relational effects of mortality rates when variables such as age, life expectancy, marital status, gender, and social class on death rates are controlled. Other factors include the effects of death on the family composition, theories of population growth and decline, and sexual activity.

Disposition of the Deceased: Representing one of the larger Reader's Guide categories, this section encompasses entries on the historical practice of mummification in ancient Egypt and the more contemporary entries up to the societal need to commemorate its heroic fallen warriors with entries such as Cemeteries and Columbaria, Military and Battlefield and the Tomb of the Unknowns. The recent movement to establish green burial and virtual cemeteries and the personal need to remember family pets through burial in pet cemeteries also have representative entries.

Funerals and Death-Related Activities: This category identifies the importance of death on the body politic through its social cultural rituals. This is aptly demonstrated with entries that cover clothing and fashion, cosmetic restoration, the death notification process, and the funeral industry.

Legal Matters: This category includes topics such as the death certificate, equivocal death, forensic science, the legalities of death, and the psychological autopsy. Topics of more recent social significance include living wills and advance directives and viatical settlements.

Mass Death: This noteworthy category of topics holds historical and contemporary significance it that it covers the conditions that result from war, terrorism, and disease. The additional inclusion of tragic events such as school shootings, genocide, and the Holocaust make this a section that will draw attention to what has been referred to as the inhumanity of the human species toward its own.

Process of Dying: From entries such as The Art of Dying (*Ars Moriendi*) and Quality of Life, Halo Nurses Program, and Life Review to the entry Persistent Vegetative State, this category of the Reader's Guide is designed to keep readers reading one interesting topic after another. It is full of history of the hospice movement and addresses the influence advancing technology has on preserving life as well as maintaining the dignity of the dying.

Religion: The institution of religion has important implications for dying and death and for those who are interested in eschatology. Included are entries that address the major world religious beliefs and traditions as well as the spiritualist beliefs of the more ancient past. The perspective of nonbelievers also is offered.

Rituals, Ceremonies, and Celebrations: Celebrating the past includes honoring the dead. These entries

nicely complement the previous classification of religious oriented entries while also offering a convenient category of topics that describe cross-cultural events such as Day of the Dead, funeral conveyances, Ghost Month, Halloween, Memorial Day, and holidays of the dead. The concept of postself and the funerary custom of sin eating make this a most interesting category of entries.

Suicide, Euthanasia, and Homicide: A set of topics with a sociohistorical and legal legacy, many of the entries in this section suggest the same may be true for the contemporary experience. Suicide was once considered illegal behavior, and the penalty for a failed suicide attempt was, ironically, death. At another point in time, the penalty for a successful suicide was state confiscation of the deceased's property, a clear detriment to survivors. Euthanasia or an easy death is a cause for ethical outcry and for some individuals a moral outrage, while the homicide concept represents a variety of contemporary subcategories that address different interpretations of those acts that result in the taking of the life of another.

Theories and Concepts: The foundation of an area of study lies in its theories and concepts; the same is no less true for thanatology. This section presents topics that conceptualize and portray death and the human experience with an interdisciplinary sociocultural perspective that also includes topics on demography, education, economics, and history.

Unworldly Entities and Events: The final category represents the unusual, but may, for some readers, represent one of the more interesting categories. These well-written entries include Curses and Hexes, *Frankenstein*, Ghost Photography, Ghosts, Witches, and, finally, Zombies, Revenants, Vampires, and Reanimated Corpses.

Visual Aids

The selective use of charts, figures, graphs, tables, and pictures (e.g., the use of a life table for the entry Life Expectancy) is designed to enhance the reader's impression of the topic. Although tables usually contain an array of interesting descriptive and inferential information such as is found in the entry Death, Line of Duty and the entry Life Expectancy, most of the information of this nature has been integrated within the well-developed descriptive narratives crafted by the contributing authors who are so well versed in their topic that visual aids are not necessary. Where these visual aids are utilized, however, the effect is most dramatic. One such example is that of the entry Clothing and Fashion, Death-Related, which has a pictorial display of individuals who have fashioned their burial cloths. Another example is the Funeral Conveyances entry for which many exquisite pictures of hearse wagons and other modes of transportation of the dead are provided.

A Scholarly Library Reference and Resource for the Novice and Other Interested Readers

The *Encyclopedia of Death and the Human Experience* is intended as a resource for the upper division undergraduate student as well as others interested in this intriguing area of study. With such an array of topics that include traditional subjects and important emerging ideas, the encyclopedia will undoubtedly enhance the research efforts of the undergraduate who seeks to develop that challenging class paper. Lay readers also will find much to stimulate their thoughts. For the graduate student and the faculty member who strive to secure a compendium statement for lectures or for establishing a basic research agendum, this encyclopedia will prove to be a most useful resource.

The *Encyclopedia of Death and the Human Experience* is the result of the contributions of many people. The entries were crafted by individuals who are well known and well versed in the complexities of the dying and death arena. Many of the contributors to this encyclopedia have long been recognized as the founders of, and contributors to, this important area of teaching and research study. In addition, a number of in-service practitioners who do not always receive appropriate recognition are well represented; in this instance their entries blend nicely within the overall structure of the encyclopedia. Finally, some very interesting and intriguing entries have been created by rising scholars whose current efforts lend themselves to potential national and international recognition in the near future.

Dennis L. Peck

Introduction

Humans are the only knowledge-accumulating animals. The history of humankind is fundamentally the history of, search for, acquisition of, and accumulation of knowledge. With accumulated knowledge, humans have been able to survive, endure, and prevail. With knowledge, they can adapt to the physical and objective world in which they live, with its changes in climate, terrain, and weather and its wide variety of flora and fauna. Knowledge enables us to adapt to the social and subjective world in which we live, to form meaningful relationships with other people, and to meet the collective need for understanding. Coming to understand the world in which we live enables us to solve problems, overcome challenges, and confront uncertainties and fears. Knowledge expands at an exponential rate, precipitating the development of technology, driving the increasing rate of progress, and enhancing the quality of life and the human condition.

Prehistoric humans existed in a state of ignorance. They lived in a world of mysteries and enigmas. They did not know why the sun rose and set, or why the moon changed shape and brightness. They did not understand rain, or thunder, or lightning. They did not understand seasonal differences in weather and climate. They did not understand why they sometimes became ill. Perhaps the greatest enigma of all was death. Why did their loved ones become sick and die, and why did the bodies of the dead become cold and stiff? The body was still there, but what had happened to the spirit within the body?

Prehistoric burials provide insight into how inhabitants of that era answered these questions by constructing belief systems regarding death, the dead, and existence beyond death. Prehistoric people may well have concluded that their cold, stiff companions were simply in some form of lengthy sleep. They may have conceptualized a bifurcation or separation of body and spirit in which the spirit left the body, as in a dream, and went elsewhere, perhaps to return at some later date. Such an explanation suggested that there must be some type of existence beyond death. The fact that the dead were often buried with stone implements and cooked food reinforces the conclusion that these prehistoric people believed in an existence after death in which their dead comrades would need food and tools.

The decision to bury the dead body, often in caves, was likely motivated by the obnoxious smell of the putrefying body, the concern that the smell might attract predators, and the desire to keep their loved ones close at hand and protected or insulated from the elements and animals, in anticipation of the return of the spirit to the lifeless body. Deceased individuals were sometimes buried in a sleeping position, laid to rest, as it were. Archeological evidence suggests that the buried bodies had sometimes been smeared with red ochre (a type of clay dust), possibly to simulate the appearance of blood, like that on an infant just after birth. Perhaps this practice was intended to magically precipitate or facilitate a rebirth from "mother earth," or even reincarnation or rebirth as a different individual (or as an animal).

Archeological evidence indicates that many prehistoric burials contained grasses, tree boughs, and other soft vegetation, a further indication that prehistoric peoples were concerned about the comfort and well-being of the dead. They may also have believed that the dead would somehow be aware of their efforts to make the grave comfortable. In some burials, the paleo-remains of bright flowers were found, suggesting affection, reverence, and respect for the dead. In some burials, there was archeological evidence of ibex skulls and horns

stuck in the ground in a circular fashion around the body. In others, there were similar, curious but stylistic arrangements of animal remains near the burial site. This indicated that a degree of ritualism attended the burial. Most importantly, the evidence and inferences uncovered in these archeological gravesites demonstrates that these prehistoric humans had well-defined death belief systems.

Over the millennia, death belief systems became more elaborate, convoluted, and more esoteric, being shaped by the cultural contexts in which they were constructed and evolved. These complex death belief systems served to frame death and the dead in a more understandable and controllable fashion and played an important role in the origin of religions. The evolving religious belief systems had at their core conceptualizations of death and the afterlife, and notions of through which mechanisms one could achieve the afterlife.

Totemism is another example of the evolution of death belief systems. Archeologists suggest that the dreams of prehistoric peoples may have included images of certain animals, and conceivably even some type of relationship with the animal. Such dreams may have led prehistoric people to postulate linkages between humans and special types of animals, and such beliefs may have been the origin of totemism. Totemism is the concept that there is a special relationship between a particular type or species of animal (or even plant) and the members of some social groups (especially kinship groups). The linkage often involves a protective reciprocity and a spiritual relationship among humans, animals, and nature. This belief system includes the idea that humans are descended from their totemic animals or that humans and their totemic animals are descended from similar spirits. It is thought that when a human or totemic animal dies, their spirits mingle with each other in some spiritual sacred place. One of these kindred spirits (human or animal) may enter the body of a woman, impregnating her; thus, human or totemic animal spirits may be reborn in either human or animal form. Such beliefs were the progenesis of reincarnation, which became the basis of death belief systems and later evolved into more complex religious systems.

The English philosopher Herbert Spencer posited that religion was the product of the fear of death and the dead. In effect, death belief systems were the origin of religious belief systems, which, in turn, evolved over time into more organized and coherent religions. It was through religion that humans were able to conceptualize, confront, control, and transcend death. Men and women could neutralize and assimilate the prospect of death through adherence to their religion and the death belief systems component to it.

By the time the ancient civilizations of Asia, the Middle East, and Egypt emerged, knowledge about death and scenarios concerning existence after death had expanded and proliferated to the point where it was sometimes aggregated into books or other records. An example of this is the *Papyrus of Ani,* more popularly known as *The Egyptian Book of the Dead,* which was written and compiled somewhere around 1240 B.C.E. The *Papyrus of Ani* is a 78-foot funerary papyrus scroll or roll that contains vividly colored images or vignettes of scenes of existence in the afterlife, accompanied by an extensive text in hieroglyphs. Its purpose was to assist its owner in the next world. This collection of texts based on the religious views of that time includes prayers, incantations, rituals, spiritual visions of the afterlife, and descriptions of the soul's journey in that existence—essentially a kind of encyclopedia of Egyptian eschatology (the study of scenarios of existence beyond death).

Over the centuries, aggregated knowledge of death, dying, and/or the afterlife appeared in many forms. For example, *The Tibetan Book of Living and Dying* contains descriptions of the afterlife, instructions on attending someone who is dying or recently has died, prayers, and a guide for "spiritual liberation." Major religious works such as the Bible, the Qur'an, and the Torah usually included information about death and the afterlife. Compendiums of knowledge about death sometimes appeared in curious venues. For example, *senet*, an ancient Egyptian funery board game, simulated the soul passing through the myriad stations or houses component to the netherworld or hereafter. The players would cast their dice sticks and move their playing pieces across a board decorated with symbols of the various houses of the dead. This game, not unlike the modern game of Monopoly, allowed the players to symbolically act out various scenarios of the death journey. *Senet* was another example of a compendium of ancient Egyptian eschatological knowledge.

Another example of an unusual venue of accumulated knowledge about death is a long tunnel in a cemetery located just outside Taipei, Taiwan, decorated with mural scenes portraying the various stages of life, and also scenes from the afterlife that will be experienced by individuals when they die. Walking through the tunnel simulates the journey of life and death, thereby informing the visitors regarding Chinese eschatology.

During the Middle Ages, devout Christians sought to meet death with equanimity. To aid in accomplishing this, two Latin texts of accumulated knowledge about dying were published and provided instructions, protocols, rituals, and advice on how to prepare to die and achieve the good death. These texts, one long and one in a shorter version, were titled *Ars Moriendi*. The longer version, authored in 1415, was widely read and translated into various European languages, including English. Over time, it was published in approximately 100 editions and became the definitive exposition on the art of dying well.

For centuries, first in Europe and later in North America, Christianity was able to control death, "tame" it, and make it "captive," as it were. For most people, death was not only natural and inevitable but also accepted and anticipated. Through the strength of their religious belief and faith, individuals could confront the prospect of their own mortality, secure in the conviction of salvation and eternal life beyond death. For centuries, the equilibrium of religion, knowledge about death and the afterlife, and personal belief insulated individuals from the fear of death.

By the 20th century, the evolution of science and technology, combined with the dilution of religious belief, had eroded this insulation, and death was no longer "tamed" and "captive." New coping mechanisms were needed. Americans now became "death-denying," pushing death out of sight and out of mind. Death was hidden and transformed into a less fearful and traumatizing entity. Some modern-day thanatologists such as Geoffrey Gorer posited the idea that like sex being a taboo topic (pornograpy, if you will) during the Victorian era, there was a generalized taboo regarding discussions of death and dying during the first half of the 20th century. In effect, the pursuit of death denial rendered death "pornographic." Many changes in customs, protocols, and social behavior helped make death less visible and intrusive. The accumulation of death-related knowledge slowed.

After World War II, in spite of cultural efforts to maintain this façade, death was rediscovered, and the new death awareness movement gathered momentum. By the turn of the century, death had been fully rediscovered and exposed. The knowledge of death was now pervasive and was disseminated in numerous venues—the mass media, trade books, textbooks, and periodicals.

Over the centuries, and particularly in contemporary times, a variety of themes have appeared in death-related knowledge. One of the more central of these themes has been that of confronting and transcending death. Throughout history and across cultures, humans have constructed strategies and mechanisms for assimilating death. Among such strategies are constructing religious eschatological scenarios of an existence after death, denying death, developing philosophical postures to neutralize death, keeping the dead alive via spiritualism or an acceptance of the notion of ghosts, accepting accounts of near-death experiences, fostering a belief in reincarnation, and accommodating a social exchange for death.

Another theme is that of exploring causal modes of death, the variant interpretations of death based on cause and context, and the social construction of death. Although the causes of death in contemporary society are myriad, many deaths are esoteric in cause, or occur with modest frequency. There are, however, major causal modes of death. On a global basis, especially in third world countries, there are massive deaths from natural disasters, infectious and parasitic diseases, localized wars, insurgencies and revolutions, infant starvation and dehydration, and death in childbirth, to mention only some. In the contemporary United States, more than one-half of all deaths result from major cardiovascular diseases and malignancies (cancer). Other leading causes of death include stroke, pulmonary diseases, accidents, pneumonia, and chronic liver diseases. Different causes of death may have disparate social consequences. Certain modes or aspects of death are subject to contention and controversy, such as suicide, euthanasia, abortion, and capital punishment. Information about, and arguments for or against, these issues have added to the accumulation of knowledge in this area. Death is often

more a social process than an event, and significant knowledge has been generated on the anticipation of death, the process of dying, and the institutional context of dying.

Throughout history, perhaps, the most important social ceremonial response to death has been that of funeralization. The significant elements of funeralization are notification, body preparation, the structure and dynamics of funerals, cross-cultural and historical aspects of funeralization, and postfuneralization activities. A considerable body of knowledge of some significance has accrued for incorporation into this theme.

Another death-related theme is that of body disposition. The choice of body disposition is more the product of culture than personal choice. Throughout history, and in most cultures, earth burial and incineration have been the primary modes. There have been, however, exceptions to these norms, such as mummification, and today there are numerous options available, ranging from body recycling in the form of organ donations, to long-range preservation via cryonic suspension. A considerable body of knowledge pertaining to this theme has been generated and accumulated.

A theme of some centrality is that of grief, bereavement, mourning, and survivorhood. Much research, writing, and scholarship has addressed these topics and produced a substantial literature. Although much of this work has been done in recent years, there was also earlier discussion of these issues. For example, toward the end of the 19th century, most books of etiquette devoted almost one half of their contents to bereavement and mourning behavior.

There are multiple themes of death in artistic creations, including paintings, architecture, sculpture, literature, music, and drama, to mention but some. Some thanatological artistic impressions conceptualize death in a variety of forms. Others focus on the confrontation with death or the cause of death. Yet others depict grief, bereavement, and mourning. Obviously these themes have their roots in antiquity, with the result that there is a vast amount of knowledge in this area.

Death is not without its legal parameters, and a substantial amount of thanatological knowledge deals with legal issues. Some death-related legalities are centuries old, such as the matter of testamentary inheritance. Other legal concerns, such as death certificates, cemetery regulation, and the notion of wrongful death, are somewhat more recent. Still other legal matters, such as living wills and the concept of thanatological crime, are quite contemporary.

Humans like to look ahead and seek glimpses of the future. Already futurists and other scholars of prognostic inclination are constructing scenarios of events, processes, products, changing attitudes, and other death-related human social, death-related activities. These endeavors promise a new plethora of knowledge.

Knowledge often proliferates to the point of becoming massive, unwieldy, and unmanageable. To be useful, knowledge must constantly be sorted, arranged, packaged, stored, even pruned, and configured into practical forms and be readily retrievable. Works such as dictionaries, anthologies, bibliographies, compendiums, directories, handbooks, and encyclopedias often facilitate this accomplishment.

The *Encyclopedia of Death and the Human Experience* attempts to make death-related knowledge available, accessible, and readily retrievable. With approximately 330 concise, informative, and authoritative entries authored by a group of eminent scholars from many countries, it covers the field of thanatological knowledge in a comprehensive fashion. The entries reflect all of the death-related themes previously articulated and represent the latest state of knowledge on all of the topics. Hopefully, this reference work will appropriately inform and instruct the reader seeking to better understand the enigma of death and its import for the social enterprise.

Clifton D. Bryant

Acknowledgments

The *Encyclopedia of Death and the Human Experience* is the summation of the Advisory Board members—Andrew Bernstein, Douglas Davies, Lynne Ann DeSpelder, Kenneth Doka, J. C. Upshaw Downs, Michael Kearl, Michael Leming, John McIntosh, Robert Neimeyer, and John Williamson—who offered so many well-received recommendations, the contributions of the many authors who gave freely of their time and talent, and the dedication and diligent efforts of the associate editors. This encyclopedia was made possible with the most capable assistance of the associate editors, Drs. Kelly Joyce, Vicki Lamb, Jon Reid, Hikaru Suzuki, Michael Taylor, and Lee Garth Vigilant. Each of us was familiar with editing; however, none of us knew what to expect in editing entries for an encyclopedia given the parameters are quite specific (in a general sort of way). But we did work it out, sometimes through trial and error, and we learned from each other. Perhaps more importantly, the contributing authors had a great influence on this learning experience and, for the most part, each of the contributors responded to our editing, and to what I will describe as constructive suggestions, in a most positive manner. Ultimately it is to this fine group of authors and editors that this encyclopedia is dedicated.

But there are many individuals to whom a special appreciation is appropriate. Rolf Janke is to be thanked for having conceptualized the notion of developing an encyclopedia on death and dying and for having made the decision to operationalize such an effort. We hope that the product fulfills his vision. The initial interest expressed by Acquisitions Editor James Brace-Thompson was instrumental in moving this project from idea to fact. Along with the input provided by Ms. Diana Axelsen, the assistance of Mr. Brace-Thompson was influential in the creation of the 325-entry headword list upon which this encyclopedia was built. Over the course of several months, some additional topics were suggested by contributing authors, of which five more topics representing emerging areas of analyses were added. The resulting final list of 330 entries makes this encyclopedia extraordinary in its coverage of the field.

From the preliminary stage of preparation and training to become familiar with the Sage Reference Tracking system to the submission of the final manuscript to the production editor, two Sage staff members were to prove invaluable to the completion of the manuscript. The contributions of Development Editor Ms. Sara Tauber and Systems Coordinator Ms. Laura Notton are too numerous to list. Each was responsive to any request for assistance whether from author or editor; each was supportive and encouraging of our overall effort.

Production Editor Tracy Buyan was kind enough to assign copy editors Ms. Amy Freitag and Ms. Colleen Brennan to finalize the process. Professional in presentation and thorough in action, each of these individuals made the final phase of the project a most interesting and easy experience.

And finally to my wife Peggy, I again express my deep appreciation and love for her support, patience, and on occasion her invaluable assistance rendered when the need for such assistance was essential to maintaining a semblance of organization and structure. The commitment to carrying out this project may not always have been understood, but she did not waiver in providing the support essential to completion of the task. Ultimately Peggy came to recognize that for me this project has been a labor of love.

Dennis L. Peck

A considerable measure of gratitude is owed to Heidi Browne, who worked tirelessly on this project, doing library and computer research, solving computer problems, assisting in compiling lists and death-related websites and organizations, generating bibliographies, and tracking down fugitive literature on death and dying. She rendered innumerable other valuable services during trying times. Many thanks to her for being such a stalwart member of the team.

I am deeply appreciative of the efforts of my coresearcher, publishing partner, and wife of 52 years, Patty Bryant, who handled all of my e-mail traffic, maintained e-mail logs, handled myriad administrative and operational details, poured over bibliographies, and searched the web in the process of aiding me in identifying and recruiting a distinguished editorial group. She spent countless hours searching my 30 years of archives of research and lecture notes on death and dying and my extensive library of thanatological books in the search for meaningful entry topics. She provided me with assistance, advice, counsel, and encouragement for all of which I owe her an enormous amount of gratitude, love, and affection.

Clifton D. Bryant

Abortion

Abortion is the termination of pregnancy before the embryo or fetus can develop to the stage at which it can be born alive. Abortion usually is considered as induced abortion. However, in medical terms, it also includes spontaneous abortion (miscarriage), which might be due to natural causes or accidental situations. Researchers have found that unintended pregnancies are the roots of abortion, and most unintended pregnancies result from not using any contraceptive. Recent studies also show that abortion rates around the world are lowest where abortion is legal and widely available, and contraceptive use is high. There are both medical and surgical procedures for induced abortion; choice of procedure depends on the number of weeks of the pregnancy, the laws, local availability, and doctor/patient preferences.

Reasons for seeking an abortion, from a legal view, include saving the mother's life, preserving the mother's physical or mental health, rape or incest, fetal impairment, social or economic reasons, and no reasons. Abortion laws and policies have changed numerous times in various countries around the world. Pro-life and pro-choice groups often seek support from lawmakers and policymakers. However, no study has shown that the level of restrictions in abortion laws significantly affects abortion rates. The abortion debate within society is a notable phenomenon and influences public opinion and attitudes toward induced abortion. There are debates on the issues of pro-life and pro-choice, physical and mental health, minors' consent with parental involvement, and other controversies.

Whether the abortion is induced or spontaneous, the situation may profoundly affect the woman and her partner or family members in various ways, including physical, psychological, spiritual, and social ways. Therefore, abortion counseling or consultation plays an important role in the course of abortion for the woman, starting from the point of being informed about the unintended pregnancy or impaired development of the fetus and ending in a recovery room after the procedure has been performed.

History and Trends of Abortion

Before the 19th century, induced abortion was applied as a way of birth control in many countries. Pregnancies in early months terminated by using herbs, sharp instruments, or other techniques were generally accepted. In 1861, the *Offences Against the Person Act* was passed to outlaw abortion in the United Kingdom, and the Roman Catholic Church also prohibited abortion under all circumstances in 1869. Similar opinions prevailed in other countries thereafter.

Key findings on abortion trends around the world during the period 1995 to 2003, reported by the Guttmacher Institute, include (a) the global abortion rate had declined, (b) abortion rates had declined more in developed countries than in developing countries, (c) the rates had dropped most dramatically in Eastern Europe and Central

Asia, and (d) unsafe abortion rates had increased. Studies have found that the patterns of using contraception can affect abortion levels. This includes contraceptive availability, effectiveness, service quality, and improved technology. There is no evidence showing that the level of restrictions in abortion laws affects abortion rates.

European countries also experienced that a combination of sufficient information on contraception and societal acceptance of adolescent sexual relationships would lower unintended pregnancies among teenagers.

Types of Abortion

Spontaneous Abortion

A spontaneous abortion occurs in early pregnancy before the 20th week of gestation because of abnormal development or environmental factors. If a fetus dies during late gestation after the 20th week in the uterus or during delivery, it is usually regarded as a "stillbirth."

Induced Abortion

Induced abortions include therapeutic abortion and elective abortion. The former is performed for medical reasons, such as saving the life of the mother, preserving the mother's physical or mental health, or resolving other medical problems. Elective abortions take place by personal choice for social or economic reasons, such as having had enough children, wanting to delay the next birth, having relationship difficulties, having difficulties affording a child, or having been raped.

Methods of Abortion

Medical Abortion

With the use of the compound drug mifepristone, medical abortion can be performed within 49 days after a woman has become pregnant. The first use of mifepristone (RU-486) legally was in France in 1988, and it was legalized in the United States in 2000.

The regimen, a combination of different dosages of mifepristone and prostaglandin, became a contemporary abortion procedure in recent years. According to the safe abortion guidance published by the World Health Organization (WHO), mifepristone plus prostaglandin regimens have been proven to be safe and highly effective for the first 9 weeks and over 12 weeks of gestation with different dosage combinations. However, these regimens are currently only available in a few developing countries.

Surgical Abortion

Vacuum aspiration is a common surgical procedure to be used in the first 12 weeks of gestation; dilation and curettage (D&C), a standard gynecological procedure, can also be used during this period. Another common surgical abortion method, used with women who are more than 12 weeks pregnant, is dilation and evacuation (D&E).

Abortion Laws and Policies

According to English common law in the 19th century, induced abortion could be performed legally before quickening (i.e., movements felt by the mother). Both pre- and postquickening abortions were against the law in many countries. The Soviet Union in 1920 and Iceland in 1935 were two of the first countries, with legislation, to allow abortion. The United Kingdom passed the Abortion Act in 1967 to allow abortions to be performed for limited reasons. In the 1973 case of *Roe v. Wade*, the U.S. Supreme Court ruled that state laws banning abortion violated the Constitution on privacy rights.

From a legal perspective, there are seven reasons for allowing induced abortion: (1) saving the life of the mother, (2) preserving the physical health of the mother, (3) preserving the mental health of the mother, (4) pregnancy resulting from rape or incest incidents, (5) unborn child with medical problems or birth defects, (6) social or economic reasons, and (7) no need to give a reason. However, various countries have many different restrictions on abortion law. Most of the countries around the world allow abortion for the reason of saving the mother's life except for some predominantly Catholic countries, such as Chile, El Salvador, Malta, and Nicaragua, and Vatican City in Italy. Whereas under no circumstance is abortion legal in these Catholic countries, 16% of 198 countries in the world allow abortion for any reason, including "no need to give a reason."

Informed Consent

Under English common law, patients have to give their consent prior to a nonemergency medical treatment. In 1982, a panel studying "the ethical and legal implications of the requirements for informed consent" created by the U.S. Congress concluded that informed consent should consist of three important elements: (1) Patients must have the ability to make decisions about their medical care; (2) patients have to participate in the decisions voluntarily; and (3) patients have to be provided adequate, appropriate information on which to base their decisions. On the issue of the decision making, there have been extensive legislative discussions and litigations involving adolescent abortion decisions. Most abortion laws require parental involvement in the termination of adolescent pregnancies. Second, a patient has the right to make her/his own choice, and the decision should not be the result of manipulation by other people. The final element about giving information is also an ethical requirement in the practice of medicine. This information should include the nature, risks, and benefits of the treatment and the availability of, and alternatives to, abortion.

Abortion Controversy

An intentional abortion by human action has become a controversial and debatable issue through history. Induced abortion is a sensitive topic that raises political, religious, legal, ethical, moral, cultural, philosophical, and biological issues.

There are two main groups in the abortion debate: pro-choice and pro-life. These two sides have been seeking legal support and trying to influence public opinion over the course of the history of abortion. Pro-choice advocates that abortion is morally permissible and supports access to abortion, while pro-life is in favor of legal prohibition of abortion and regards it as morally wrong.

Much research and discussions have been conducted on health risks of abortion including future fertility difficulties, breast cancer, and mental health problems. While some of this research strongly asserts that abortion does have an effect on many aspects of women's health, there are also studies that show evidence that abortion is not significantly associated with the stated risks above.

Abortion Counseling or Consultation

Abortion counseling or consultation, which is also considered as pregnancy counseling, plays an important role in the course of an abortion as it is a psychologically supportive conversation session for the woman who is pregnant unintentionally and facing a critical situation to make decisions. It is also important for the woman to obtain adequate information on abortion procedure and contraceptive use afterward. In some countries, a consultation conversation is an information-oriented session, while counseling focuses more on resolving personal conflicts, emotional problems, or disturbance. And other countries use "counseling" for both psychological and informational services.

Abortion counseling can be categorized as four kinds: pregnancy test counseling, pregnancy options counseling, preabortion counseling, and postabortion counseling. All of these kinds of counseling sessions might have similar content; however, the woman may have different emotional and cognitive changes. The counselor often has to focus on her various needs at different stages along the course of abortion.

Pregnancy Test Counseling

At the time the pregnancy test comes out positive, a counselor should help the woman to understand and cope with her feelings. It might be happiness or shock, panic or excitement, or a mixture of different emotional reactions. It is also important to explore her support system and what options she has thought of.

Pregnancy Options Counseling

When facing pregnancy options, a woman needs accurate information on abortion, parenting, and/or adoption. If this is for medical reasons, she may need more medical information about the fetus and herself. The counseling session at this stage is usually seen as a crisis intervention. The client may need someone to listen to and help her calm down, clarify what would best suit her situation, and understand her ability and resources to cope with each option. Her partner or family members may also need similar help at this stage.

Preabortion Counseling

Before a woman has an abortion, she might see a counselor on the day of her procedure. She has usually deliberated on the decision. The counselor will explore how she has reached this point and feels about her decision; the level of psychological support she has received; conflicts she might have with her partner or family, beliefs, religion, or culture; and her concerns and fears about the procedure. The counselor can also empower her ability to handle some issues that might arise after the abortion.

Postabortion Counseling

Women who have abortions seldom seek counseling after the incident, and since this is confidential, neither would abortion providers call patients back to check if they are fine or not. However, there is a short time for counselors or medical staff to observe whether the woman shows any sign of emotional disturbance in the recovery room. She may feel relieved, physically uncomfortable, out of control emotionally because of the medicine she is given for pain relief, guilty, or sad. The topic of birth control is usually discussed at this point, and according to professional experience, most women are highly motivated and eager to receive related information. For those who are distressed by relationship problems, the counselor may consider giving them a local referral list of counseling providers or arrange adequate resources for the clients.

The conclusion is that abortion is a unique experience in human beings not only for women themselves but also for their partners or important family members. This is not just a medical procedure. It also has deep effects in human experiences and development pertaining to social, psychological, religious, political, ethical, and cultural issues. As a result, abortion is not only one of the medical services, but a multidisciplinary service including medical, psychological, legal, spiritual, and social fields.

Yu-chan Li and Cypress W. Chang

See also Ambiguous Loss and Unresolved Grief; Grief and Bereavement Counseling; Infanticide; Informed Consent; Legalities of Death; Miscarriage and Stillbirth

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Accidental Death

To die by accident is to experience a form of mortality that is unexpected, unplanned for, and unintentional. The key component to establishing a death as an accident is the absence of intentionality in its occurrence, namely, that the decedent did not intentionally act to produce a deadly outcome and that the deceased did not want to lose his or her life. Accidental death is one of the leading causes of deaths in the United States and is consistently ranked among the foremost causes of death worldwide.

According to Centers for Disease Control and Prevention (CDC) statistics, accidental mortality is the fifth leading cause of death in the United States, ranking behind heart disease, malignant neoplasms, cerebrovascular diseases, and chronic lower respiratory infections. Moreover, accidental death increasingly receives public safety and epidemiologic interventions directed at reducing its incidence. These efforts have resulted in public policies that require seat belts and airbags in automobiles, stiffer penalties for driving under the influence of alcohol, and the use of smoke detectors in public and private buildings. Because accidental death has consistently ranked in the top 10 leading causes of mortality over the past century, public health efforts at eliminating or reducing its occurrence have also led to the creation of some

noteworthy federal agencies such as the Occupational Safety and Health Administration since 1971, which aims to reduce work-related injuries and death; the Consumer Product Safety Commission since 1972, which strives to ensure the safety of consumer products; and the National Transportation Safety Board since 1967, which investigates transportation-related deaths and injuries and makes recommendations to improve the safety of the traveling public. In addition to these federal agencies, the lobbying efforts of social movements, such as Mothers Against Drunk Driving, which, since 1980, has worked to reduce alcohol-related motor vehicle injuries and fatalities, have played a major role in bringing alcohol-related injuries and deaths to the forefront of discussions on prevention efforts. Yet, despite the work of these organizations, accidental mortality has not risen to the same level of public awareness and concern as the other 15 leading causes of death in the United States, and this relates to the very conception of what an *accident* is.

In the collective consciousness, an accident is defined as something that occurs by chance or the result of fate—an event or an outcome that people have little, or no, control over. And the thanatological assumptions surrounding accidental deaths are entrenched in this line of thinking because nobody intentionally dies by mistake. That accidental deaths are seen as the result of fate, bad luck, unfortunate circumstance, or statistical probability may explain why public health efforts to educate and lower the risk of accidental mortality are not as entrenched in the collective conscience as are other campaigns intended to address the incidences of mortality from the other leading lifestyle-related causes. An accidental death, in the public's consciousness, is too often an unfortunate occurrence that was unforeseen and unanticipated, a mistake-related mortality.

Leading Types of Accidental Deaths

According to the Centers for Disease Control and Prevention (CDC), between the years 2000 and 2004, some of the leading causes of unintentional deaths for all age groups included motor vehicle accidents (214,434 deaths), poisonings (84,663), falls (80,540), unspecified accidents (33,134), suffocation (25,069), fire/burn (16,376), and drowning (16,376). Moreover, the CDC statistics on the occurrence of accidental death show that the risk of succumbing to unintentional mortality changes with different stages in a person's life. The accidental death risk for a toddler will be significantly different from that of a teenager's. Indeed, the leading cause of accidental deaths for children under age 1, according to the CDC, is unintentional suffocation, but between 1 and 3 years of age, it shifts to motor vehicle accidents. For adults over the age of 50, falls are the most prevalent cause of unintentional mortality. Furthermore, there were 108,694 accidental deaths in 2004, a figure that was higher than the 93,592 deaths in the year 2000, a near 14% increase in the number of unintentional deaths for this 5-year period, making unintentional death the leading cause of mortality for the first 40 years of life. However, it is important to remember that the age-adjusted accidental death rate per 100,000 people has actually fallen significantly over the past 4 decades in the United States, with 63.1 recorded accidental deaths per 100,000 individuals for the year 1960, compared to 37.7 deaths per 100,000 people for the year 2004.

Motor Vehicle Fatalities

The sheer number of unintentional traffic fatalities, an average of about 42,000 deaths per year since 2000, deserves special consideration above the other categories because it represents close to 40% of all accidental deaths. About 116 persons will die each day as a result of an automobile accident, a number that would be much higher but for advances in safety such as front and side airbags, seat belt restraints, antilock brakes, and stability control technologies. Indeed, although the contemporary automobile death rate is high, it is still below the historic peak in 1969, a time before the enactment of safety innovations and regulations. Nevertheless, the United States averages one traffic fatality every 12 minutes, and the demographic picture of traffic deaths show that being young and being male are the two most common risk factors that show up in fatality statistics.

Accidental death seems to be a universal corollary of "driving while young." In the year 2004, a total of 4,767 teenagers between the ages of 16 and 19 were killed in motor vehicle accidents, and

another 400,000 received injuries that required hospitalization, according to CDC statistics for 2006. In fact, accidental death in vehicle crashes is more likely to affect this age group than all others, and gender is, once again, a crucial variable in the data on motor vehicle fatalities.

The rate of death for teenage male drivers 16 to 19 years old was 1½ times greater than the death rate for their female cohort according to 2004 CDC statistics. Teenage male drivers are more likely to report risky driving behaviors, such as speeding, driving without seat belt use, and driving while under the influence of alcohol. In fact, the teenage motor vehicle death rate is so alarming that the National Transportation Safety Board now advocates the most austere policies for young drivers, including (a) graduated drivers license statutes, (b) laws restricting the use of communications devices while driving, and (c) laws setting limits on the number of passengers a teenage driver can transport. In addition to advocating for these teen-specific driving regulations, the National Transportation Safety Board would also like to see the adaptation of mandatory adult seat belt restraint and child occupancy laws in all 50 states and the universal adoption of the .08 blood alcohol standard for driving under the influence (DUI) infractions.

What the National Transportation Safety Board stratagem suggests is that most traffic fatalities are not the result of fate or back luck, but poor choices on the part of drivers. While all automobile accidents are the result of road or weather conditions, automobile mechanical failure, and/or problems with the driver, the *overwhelming* amount of traffic fatalities are caused by poor choices on the part of drivers. For example, the National Highway Traffic Safety Administration reports that intoxicated driving and excessive speeding account for close to 70% of all traffic fatalities nationwide. Moreover, of the 42,642 people killed in traffic accidents in 2006, 17,602, or 41%, were alcohol-related deaths. These statistics suggest that human error in decision making, in either driving while intoxicated or with excessive speeds, is the cause of most accidental deaths on U.S. roadways. That society still refers to these fatalities as "automobile accidents" seem to suggest a link between poor decision making and the lack of culpability in outcome. Because of this assumption, some policymakers and accident researchers now suggest the phrase "automobile collision" as a better moniker for what is *really* taking place on American highways.

Accidental Fall Deaths

Depending on the year of reported CDC mortality statistics, unintentional mortality by falling is either ranked as the second or third most common type of accidental death. Between 2000 and 2004, the total number of deaths by unintentional falls was 80,643, making it the third leading cause of unintentional mortality for this time period, behind unintentional poisoning and motor vehicle fatalities. The CDC reports that among adults 50 years and older, unintentional falls is the leading type of accidental death, with about 14,000 deaths per year for this age group. The elderly are acutely affected by this type of unintentional death because of morbidity factors (e.g., neuromuscular and musculoskeletal diseases such as Parkinson's disease and osteoporosis) that increase the likelihood of accidents. According to CDC statistics, the home is the most likely setting for falls, accounting for about 60% of all accidental falling deaths.

Gender and Accidental Deaths

CDC statistics on accidental deaths show a distinct gendered pattern in occurrence rates. Men are more likely to be the victims of accidental mortality in almost every category of accidental death. At younger ages, teenage boys are more likely to be the victims of automobile accidents and drowning—more than 1½ times more likely to be victims of motor vehicle fatalities and more than 3 times more likely to drown than are girls. Among adult unintentional poisoning deaths, men are 2 times more likely than women to be victims. Finally, among unintentional falling deaths between the years 2000 and 2004, males accounted for 53% of those deaths.

Social scientists attribute the disparity in accidental mortality between men and women to differences in the gender socialization boys and men receive into masculinity, where certain risk-taking behaviors and activities are normalized as part of the process of becoming a man. Also, men are more likely to participate in activities that involve greater levels of risk, such as excessive speeding and driving under the influence, and this tendency

accounts for the difference in accidental mortality between boys and girls, and men and women.

The Impact of Accidental Traffic Injuries and Fatalities: Economic and Psychological Costs

Automobile accidents are a ubiquitous and common occurrence that carries significant economic and social costs. In 1990, there were 6.4 million traffic accidents or crashes on U.S. highways, and there were 6.1 million in 2005. The National Highway Traffic Safety Administration estimates for the year 2000 put the total economic cost of all motor vehicle accidents, injuries, and fatalities at $230.6 billion, which includes lost productivity costs of $61 billion, property damage costs of $59 billion, and medical expenses at $32 billion.

The impact of motor vehicle accidental injuries and deaths is not just economic or social. There is a tremendous personal cost to the high rate of accidental death and injury by automobile. For example, in 2005, 101,034 Americans were involved in an automobile accident either as a driver or passenger in which a person was killed. In fact, motor vehicle injuries and fatalities are the leading cause of trauma for American males and the second leading cause of trauma for American females. Moreover, it is the most common cause of post-traumatic stress disorder, which presents itself in a host of postaccident psychiatric morbidities such as phobic avoidance of driving, depression, and increased anxiety. Epidemiological evidence from the American Psychological Association indicates that anywhere from 10% to 40% of Americans involved in a life-threatening or fatal automobile accident will develop post-traumatic stress disorder.

Accidental Death Issues

There are several conceptual problems surrounding the concept "accident" and "accidental death" in particular. An accident is something that is the result of pure chance, an outcome that was unexpected and unintentional. An accidental death is an unfortunate, unanticipated, and surprising event that no one can foresee. But this is a limited use of the concept of accidental death, especially when the vast majority of accidents are not really accidents of chance but rather accidents of folly, negligence, and blatant human misjudgment. One accident researcher cites that as much as 60% to 80% of all accidents might be the result of human errors. The National Highway Traffic Safety Administration reported that 41% of the 42,642 traffic deaths in 2006 were directly related to alcohol consumption and impaired driving. Can we really call these deaths *accidental deaths*? Many accident researchers argue that we cannot.

In one of the most important reports on the accident controversy, written in 1961, Suchman's *A Conceptual Analysis of the Accident Phenomenon*, a reevaluation of the way society conceptualizes life's unexpected events is suggested. By the criteria established at the time, an event must meet three necessary conditions and satisfy four qualifying assessments in order to be considered an accident. These three necessary conditions are (1) intentionality, (2) unavoidability, and (3) expectedness. The first, *intentionality*, is the most commonly used criterion, and one too often applied alone. The questions most frequently asked to ascertain intentionality are "Was it your intention to cause this accident?" and "Did the decedent intend to die?" *Unavoidability* relates to the degree to which the accident victim could have taken reasonable steps to avoid the occurrence. Finally, the degree of *expectedness* relates to the likelihood that the victim might have anticipated the outcome. In the case of aggressive driving and speeding, *expectedness* relates to the probability that one's action might cause an accident. But aside from these three factors, it is important to consider (1) the degree of warning that may have precipitated the event, such as admonitions against the perils of driving under the influence or excessive speeding; (2) the degree of negligence involved in the act that led to the accident; (3) the degree of an individual's misjudgment; and (4) the duration of the occurrence itself.

Finally, there is an unsettled debate in the literature on accidental death and injury concerning the issue of *accident proneness* and whether or not the phenomenon even exists. Studies on accident proneness—that is, the likelihood that personality traits and attitudes toward risk-taking behaviors might be factors in explaining higher rates of accidental deaths or injuries in certain groups or clusters of people—have been inconclusive and highly controversial. While the literature on accident

proneness suggests that there are some personality traits, such as youthful impulsivity and a penchant for sensation-seeking activities, that might explain differences in accidental rates between teenagers and adults and between men and women, there are also structural features that make this person-blame approach to accidents problematic, namely, that low socioeconomic status increases an individual's likelihood of experiencing an accidental death or injury, or that social and environmental factors, such as gender socialization, make it more acceptable for some groups to be risk-prone. Yet, despite debates on the accident proneness phenomenon, there is a psychological assessment commonly used to measure a person's proneness level: the Accident Proneness Test.

Classifying Accidents: Subintentional Behaviors, Equivocal Deaths, and the Psychological Autopsy

Some scholars argue that too often, suicides are classified as accidental deaths when there is no clear evidence to suggest intentionality, especially when the decedent leaves no indicator that might suggest suicide. There is also a class of subintentional actions that are self-destructive or reckless deeds that can hasten death or that can heighten the possibility of dying even if suicide is not the *intent* of these actions. Subintentional behaviors cover a wide range of actions from aggressive driving under the influence of alcohol, to free-wheeling drug abuse and addiction, to high-risk personal behaviors. In a subintentional death, the decedent may not have wanted to die but certainly knew that dying would be the natural outcome of his or her risky behavior. Whether or not subintentional deaths should be classified as accidents in part spurs on the contemporary debate over accidental mortality.

In 1973, Edwin Shneidman reasoned that anywhere from 10% to 15% of casualties were *equivocal deaths,* meaning that they could be classified as either suicides or accidents, but in most cases, they were likely to be classified as accidents. Many researchers believe that suicides are underreported and that many are included in accidental death statistics. To correctly classify unsuccessful parasuicides and deaths from subintentional acts, the psychological autopsy, an ex post facto investigative tool, was employed to investigate equivocal deaths, thereby facilitating the effort to correctly classify the death. The psychological autopsy also considers the degree of lethality involved in subintentional acts and parasuicide to provide an index of whether the intent of the act was suicide, the reasoning being that the greater the lethality of the method used, the more likely that suicide, and not a "cry for help," was the intent that underscored the act.

Finally, the current method of accounting for the prevalence of accidental deaths may be limited by the exclusion of entire categories of accidental mortality, such as iatrogenic and equivocal deaths.

Lee Garth Vigilant

See also Bereavement, Grief, and Mourning; Economic Evaluation of Life; Life Insurance; Medical Mistakes; Wrongful Death

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Acute and Chronic Diseases

Historically the modal cause of death is disease. Diseases, also referred to as morbidities, are commonly classified into two categories: acute illness and chronic illness. Acute illness is characterized by sudden onset of symptoms and a brief duration. Examples include influenza and chicken pox. Most infectious diseases fall into this category. Acute illness may resolve on its own, may be treated with medications, or, in severe cases, may result in death. By contrast, chronic illness has a gradual onset of symptoms and an extended course. These types of illnesses usually result from degenerative conditions, traumas, lifestyle factors, or exposure to harmful environmental agents. Examples include diabetes, Alzheimer's disease, cancer, and most forms of heart disease. Although chronic illnesses are generally not curable, in many cases the sequelae of chronic conditions can be managed behaviorally or through medical intervention.

In 1900, the major causes of mortality in the United States were infectious diseases. The three leading causes of death were pneumonia and influenza, tuberculosis, and diarrheal diseases, respectively. The life expectancy at birth, in 1900, was 47.3 years; in contrast, a baby born in 2005 has a life expectancy of 77.8 years, an increase of more than 30 years. Much of the increase in life expectancy can be contributed to the changes in the major causes of mortality, with the leading causes of mortality shifting from acute illness to chronic illness.

In the United States and other more developed countries, acute illnesses have historically been important causes of death and have produced dramatic fluctuations in mortality; the Spanish flu epidemic of 1918 is one important example. More recently, however, with the life expectancy at birth reaching approximately 75 years for men and over 80 years for women, the primary source of death has shifted to chronic illness, especially heart disease and cancer. This entry summarizes the most common fatal chronic and acute illnesses in the United States, describes the historical shift from acute to chronic illnesses as the primary causes of death (epidemiological transition), and compares the level of chronic and acute illness in the United States to levels observed in other parts of the world.

Acute and Chronic Illness in the United States

According to a recent report by the National Center for Health Statistics, "Deaths: Final Data for 2005," there were 2,448,017 recorded deaths in the United States in 2005, resulting in a crude death rate of 825.9 deaths per 100,000 population. A more detailed view of recent mortality in the U.S. population can be obtained by examining specific causes of death. The 15 leading causes of death are shown in Table 1. Of the major causes of mortality in the United States, most are chronic in nature. The two major causes of death on this list—heart disease and cancer—accounted for almost half of all deaths (49.4%) in 2005, providing compelling testament to the monolithic role that chronic disease currently plays as a cause of mortality.

Heart Disease and Cancer

Most deaths from heart disease (almost 70%) are classified as ischemic heart disease (oxygen shortage that damages the heart muscle). Even when the effects of heart disease appear suddenly, as may be the case in a myocardial infarction or heart attack, the underlying cause usually involves long-term accumulation of arterial plaque, a hardening of the arterial blood vessels (atherosclerosis), or both. Although the heart is susceptible to infectious disease (as with some types of endocarditis and myocarditis), infectious disease accounts for less than 1% of heart disease deaths.

Although in some cases cancer can kill quickly, most types have an extended course. Advances in the treatment of cancer, using surgery, radiation

Table 1 The 15 Leading Causes of Death in the United States, 2005

Cause of Death	*Rank*	*Number*	*Percentage of Total Deaths*
Diseases of the Heart	1	652,091	26.6
Malignant Neoplasms (Cancer)	2	559,312	22.8
Cerebrovascular Diseases	3	143,579	5.9
Chronic Lower Respiratory Diseases	4	130,933	5.3
Accidents (Unintentional Injuries)	5	117,809	4.8
Diabetes Mellitus	6	75,119	3.1
Alzheimer's Disease	7	71,599	2.9
Influenza and Pneumonia	8	63,001	2.6
Nephritis, Nephrotic Syndrome, and Nephrosis	9	43,901	1.8
Septicemia	10	34,136	1.4
Intentional Self-Harm (Suicide)	11	32,637	1.3
Chronic Liver Disease and Cirrhosis	12	27,530	1.1
Essential (Primary) Hypertension and Hypertensive Renal Disease	13	24,902	1.0
Parkinson's Disease	14	19,544	0.8
Assault (Homicide)	15	18,124	0.7
All Other Causes	—	433,800	17.7

Source: From "Deaths: Final data for 2005," by H. C. Kung, D. L. Hoyert, J. Q. Xu, and S. L. Murphy, 2008, *National Vital Statistics Reports, 56*(10). Hyattsville, MD: National Center for Health Statistics.

therapy, chemotherapy treatment, and other methods, have extended survival time contributing to the chronic nature of this category of disease. The types of cancer that accounted for the most deaths in 2005 were (a) cancer of the trachea, bronchus, and lung; (b) cancer of the lymphoid and hematopoietic systems; (c) cancer of the rectum, colon, and anus; (d) breast cancer; and (e) pancreatic cancer. Together, cancer of these sites accounted for about 61% of all deaths from cancer.

Other chronic illnesses among the 15 leading causes of mortality include cerebrovascular disease, chronic lower respiratory disease, diabetes, Alzheimer's disease, chronic kidney diseases, chronic liver disease (including cirrhosis), hypertension, and Parkinson's disease. Together these illnesses accounted for 18.3% of deaths in the United States in 2005.

Acute Diseases

Even though chronic illnesses are the primary causes of mortality in the United States and in other industrialized countries, acute illnesses account for a significant number of deaths annually. Two infectious diseases appear among the top 15 causes of death. Influenza, along with pneumonia, accounted for 63,001 deaths in 2005, while septicemia (bacterial infection in the blood) accounted for 34,136 deaths that same year. Finally, the human immunodeficiency virus (HIV) claimed 12,543 lives in 2005. Although HIV/AIDS is a communicable illness, advances in medical management of HIV/AIDS have significantly increased the survival time; in many cases, HIV/AIDS resembles a chronic disease rather than an acute infectious illness.

Risk Factors

Age

The risk of chronic illness rises precipitously with age. The vast majority of older adults (65 years of age or older) living in the United States report at least one chronic condition, and roughly half of the older population reported two or more chronic conditions. Based on data from the 2005–2006 National Health Interview Study reported by the National Center for Health Statistics in 2008, the 10 most common chronic conditions suffered by older adults were hypertension (53.3%), arthritis (49.6%), heart disease (31.0%), cancer (21.2%), diabetes (18.1%), sinusitis (13.8%), ulcer (10.8%), asthma (10.6%), stroke (9.3%), and hay fever (7.5%). Although not all of these conditions are fatal, they can result in diminished functional ability and significant erosion of quality of life.

Sex

Examining group differences in chronic illness provides insight into the source of sex, race, and ethnic variation in overall mortality. Age-adjusted mortality for men was approximately 40% more than women's overall mortality. Specifically, men suffered higher mortality from 9 of the 13 diseases as shown in Table 1, namely, heart disease, cancer, chronic lower respiratory disease, diabetes, influenza/pneumonia, kidney disease, septicemia, liver disease, and Parkinson's disease. Women suffer higher mortality from only one of the leading causes of death: Alzheimer's disease. No differences in mortality were observed between males and females for cerebrovascular disease or primary/renal hypertension.

Race and Ethnicity

Age-adjusted mortality for African Americans is approximately 30% greater than that for whites. African Americans had higher mortality for 8 of the 15 leading causes of death, namely, heart disease, cancer, cerebrovascular disease, diabetes, influenza/pneumonia, kidney disease, septicemia, and primary/renal hypertension. For four of these illnesses—diabetes, septicemia, kidney disease, and primary/renal hypertension—the rates for African Americans are more than double that of whites. Whites, however have higher mortality from chronic lower respiratory disease, Alzheimer's disease, liver disease, and Parkinson's disease. Hispanics exhibit considerably lower mortality than non-Hispanic whites, approximately 30% lower among all of the major fatal illnesses except diabetes and liver disease.

The Epidemiological Transition

The shift in mortality and disease patterns (acute to chronic illnesses as the leading cause of death) is known as the epidemiological transition for which three stages have been identified: (1) the age of pestilence and famine; (2) the age of receding pandemics; (3) the age of degenerative and man-made diseases. The epidemiological transition is typified by a gradual replacement of pandemic infectious (acute) diseases by degenerative (chronic) diseases as the main types of morbidity and leading causes of mortality. The age of pestilence and famine is characterized by high rates of infectious disease and mortality and low life-expectancy rates at birth. The age of receding pandemics is distinguished by lower rates of mortality, gains in life expectancy at birth, and sustained population growth. The age of degenerative and man-made disease is exemplified by continued declines in mortality and an increase in life expectancy at birth to over 50 years of age. Along with all other more-developed countries, the United States has experienced an epidemiological transition: There has been a shift from acute illnesses to chronic illnesses as the major causes of mortality, and there have been increases in life expectancy.

Causes and Consequences of the Epidemiological Transition

The primary reasons for the epidemiology transition in the United States include a rise in the overall standard of living, advancements in medical care, and improved public health measures. Throughout the 19th and 20th centuries the United States underwent an overall rise in the standard of living, based in large part on enhanced diet and adequate shelter, which greatly shaped rates of U.S. morbidity and mortality. Following the rise in the standard of living, the United States benefited from further advancements in medical care and

improved public health measures, such as superior water and sewage treatment.

The consequences of the epidemiological transition in the United States are easily demonstrated. Because declines in mortality preceded declines in fertility, the size of the U.S. population has grown dramatically. Falling mortality rates have also increased the average life span, dramatically increasing the number of Americans living to older ages. As the U.S. population ages, there is a greater prevalence of chronic illness and disability. To manage the changing health demands of an aging U.S. population, health care costs have sharply risen over the past several decades.

Although the United States adheres to the classic epidemiological transition model, the Spanish flu pandemic of 1918 illustrates the variability of infectious diseases. During the early 20th century the United States was arguably experiencing the second stage (the age of receding pandemics) of the epidemiological transition, yet the Spanish flu pandemic of 1918 affected nearly a quarter of the U.S. population and had a high mortality rate. Recently, infectious diseases have come to the forefront of media attention, and researchers are discussing a reemergence of infectious diseases such as AIDS and stronger strains of classic diseases such as tuberculosis, pneumonia, and influenza. There is evidence to suggest that infectious diseases will assume increasing importance in the future.

Acute and Chronic Illness in Global Perspective

The major causes of mortality for developed nations differ from those in developing nations. As reported by the World Health Organization, the leading causes of mortality for high-income countries are chronic illnesses such as coronary heart disease, stroke and other cerebrovascular diseases, and lung cancer. However, in low-income countries the leading causes of mortality are a mixture of chronic and acute illnesses. To illustrate, the top three leading causes of death in 2002 for low-income countries were coronary heart disease, lower respiratory, and HIV/AIDS. Such patterns of disease and health vary from nation to nation due to different socioeconomic statuses, cultures, environments, and demographic and technological changes.

In general, developing nations do not fit the classic or Western epidemiological transition as well as has been observed among the developed nations. Because of recurring aberrations the model was refined to explain the variants to the classic epidemiological transition. Thus, two models, building on the classic epidemiological transition model, are (1) the accelerated model and (2) the delayed model. The accelerated model, associated with Japan and Eastern Europe, is characterized by rapid decline in fertility and mortality rates, while the delayed model is typically associated with the poorer nations or developing nations that have maintained high rates of infectious diseases and, in turn, low life expectancy.

The differences observed in the patterns of disease and causes of mortality observed among the developing nation states are quite dramatic. Latin America provides an excellent example of the differences among developing nations in reference to the epidemiological transition. Guatemala is experiencing a delayed transition, with high rates of mortality due to acute illnesses and low rates of mortality due to chronic illnesses; in contrast, Mexico has high rates of mortality due to both acute and chronic illnesses. The differences between Guatemala and Mexico can largely be attributed to the differences in modernization level. Modernization influences the pattern of disease because it affects a nation's standard of living, public health, and medical care. As developing nations continue to see increases in living standard and public health measures, the global burden of chronic illness will also increase.

Chronic Disease in Developing Nations

The global burden of chronic illness in developing nations has been relatively unrecognized because acute illnesses kill at higher rates; however, the contribution of chronic illness, such as cardiovascular disease, from developing nations to the overall global burden of chronic illness is significant. Developing nations, which already must manage acute illnesses, face a "double burden" from the added incidence and prevalence of chronic illness. Some researchers have postulated that the increased rates of chronic illness in developing nations can be partially attributed to the effects of

globalization on lifestyle factors such as tobacco use and dietary changes.

Chronic illness is a global concern for both developed and developing nations, but the reemergence of infectious diseases has garnered international media attention. The recent outbreak of avian flu has raised concerns about a possible avian flu pandemic in the future. Many researchers see the outbreak of avian flu as evidence that a new stage of epidemiological transition may be under way, namely, the age of emerging and reemerging infectious disease. As infectious diseases, such as avian influenza and sudden acute respiratory syndrome (SARS), continue to make their presence known both domestically and internationally, it is not yet clear how these infectious diseases will impact the health of both developed and developing nations.

Chuck W. Peek and Kenzie Latham

See also Causes of Death, Contemporary; Causes of Death, Historical Perspectives; Childhood, Children, and Death; Coroner; Death Certificate; Demographic Transition Model; Medical Examiner

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Adolescence and Death

Developmental tasks and transitions influence how adolescents face mortality, and experiences with mortality very likely influence how adolescents deal with the transitions and tasks that society expects them to complete. An early influence on developmental understandings of adolescence was provided by Peter Blos, whose notions of early, middle, and late adolescence phases of development revolve around identity formation and ego integrity. Although there is no uniformity on the age ranges that encompass early, middle, and late adolescence, it is understood that (a) adolescence involves more than the teenage years, (b) adolescence begins with puberty, and (c) a convenient U.S. marker for early, middle, and late adolescence is schooling: Early adolescents are junior high or middle school students (~10–14 years old), middle adolescents are high school students (~15–18 years old), and late adolescents are traditional-age college students (~19–22 years old).

The developmental push for achieving identity integration focuses, in early adolescence, on separating emotionally from parents; in middle adolescence, on developing a sense of proficiency or mastery; and in late adolescence, on entering into and maintaining intimate interpersonal relationships. Consider, for instance, the complexity facing a 13-year-old early adolescent whose struggle to achieve emotional separation from her parents is embedded in the unexpected death of her father from a heart attack. Some empirical evidence, longitudinal and cross-sectional, suggests that adolescents facing life crises over deaths of family members or friends become more mature than same-aged, nonaffected peers. Cascading effects of bereavement on adolescents can be seen prominently in the

impact on academic pursuits. High school and college students' grades in the first few months of bereavement suffer, and even retention in college can be affected.

There is widespread attention to changes in cognitive development that enable older children and adolescents to attain what is considered a mature understanding of death. People who grasp that death is (a) irreversible, (b) happens to all living organisms, (c) can result from internal or external causes, and (d) produces the end of bodily functions are said to possess a mature understanding of death. Remarks that death leads to a life after death are typically dismissed as indicative of an immature concept of death, despite the fact that the great majority of adults, at least in the United States, hold such a view. There is growing awareness, as well, that many adults struggle with a mature understanding of death when faced with the death of someone loved.

Ambiguity colors individual adolescents' acceptance that mortality applies to them. The source of this ambiguity is a twofold form of adolescent egocentrism, or what has been identified as mistaken inferences about individual uniqueness (a "personal fable") and as narcissistic expectations about others' awareness of one's existence (an "imaginary audience"). This ambiguity about the universality of death is sometimes described as a belief in invulnerability, but recent research into developmental neuroscience raises serious doubt about adolescents' having delusions of invulnerability. It is doubtful that adolescents threatened with imminent death (e.g., realizing the car in which they are driving is going to hit another vehicle head on) dismiss the prospect that death applies to them; further, it is doubtful that adolescents from ethnic or racial groups at significant risk of homicide dismiss the likelihood that death can happen to them.

Adolescent Mortality

Although adolescents die from a variety of causes, the three major reasons are accidents, homicide, and suicide. Life-threatening illnesses do take the lives of adolescents, but deaths from cancers, diabetes, or heart disease, for instance, are considerably more prevalent later in the life span. The World Health Organization has published concerns that rites of passage within adolescent subcultures place adolescents at risk of death: These rites of passage include behaviors such as binge drinking, sexual promiscuity, drunk driving, and violence. Throughout the world, with the obvious exception of death due to pregnancy complications, adolescent males are at much higher risk of mortality than are adolescent females.

Deaths Due to Accidents

Mortality statistics reported by the World Health Organization underscore the fact accidents comprise the largest plurality of deaths during adolescence. Such statistics apply whether the adolescents live in developed or developing countries. For instance, deaths due to accidents comprise approximately 46% of deaths of adolescents in Australia, France, and the United States, and approximately 37% of deaths of adolescents in Mexico, the Ukraine, and Belarus. Vehicular accidents typically are the major cause of adolescents' accidental deaths.

Deaths Due to Murder

According to the World Health Organization, homicide is a leading cause of death for African American adolescents and for adolescents in El Salvador, Brazil, and Russia; homicides account for approximately 35.5% of adolescent deaths in those countries. Among developed countries, only in the United States does homicide form a leading cause of death for adolescents. In the United States, homicides account for approximately 16% of adolescent mortality, whereas in countries such as Australia, Canada, and France, homicides account for approximately 2% of all adolescent deaths.

Deaths Due to Suicide

Suicide is the second leading cause of death for adolescents around the world, and international data indicate the adolescent suicide rate has increased exponentially: The number of completed suicides has increased 60% since the 1950s, and the number of suicides completed daily extends from 5.4 in Japan to 20.8 in Russia. In the United States, there are on average 11 adolescent suicides a day. In approximately one third of all nations, adolescents are the age group most at risk of

taking their own lives. In all countries males complete suicide much more often than do females, a phenomenon attributed to the highly lethal means males typically choose in contrast to the less lethal means typically favored by females (e.g., the use of firearms or hanging versus a drug overdose).

Deaths Due to Life-Threatening Illnesses

Illnesses seemingly endemic to adults do strike some adolescents, and thus there are incidents around the world of adolescent deaths due to malignant neoplasms, leukemia, diabetes, heart disease, and circulatory problems. The mortality rate of such deaths comprises approximately 16% of all adolescent deaths worldwide. Percentages of adolescent deaths due to fatal illnesses in 2000 include Australia (16.7%), Canada (13.9%), Cuba (22.4%), France, (15.8%), Russia, (14.3%), the United Kingdom (20.3%), and the United States (15.6%).

Adolescent Bereavement Due to Deaths

Diverse studies suggest that bereavement is a much more common experience for adolescents than previously believed. Many high school students are bereaved, and up to 20% have witnessed someone's death. Convenience samples on several college campuses indicate that 22% to 30% of students are within the first year of grieving the death of a family member or friend.

Bereavement researchers have concentrated primarily on adolescents' responses to the deaths of parents and to the deaths of siblings. Scant attention has been paid to the adolescents' responses to the deaths of friends, grandparents, or pets.

Adolescent Bereavement Over Parental Death

Two major research programs that examined adolescent bereavement following the death of a parent were conducted at Massachusetts General Hospital by William Worden and Phyllis Silverman and at Arizona State University by Irwin Sandler. These carefully designed longitudinal studies reported that the death of a parent fundamentally challenged the adolescents' reliance on predictability of events, leading them to be more anxious and fearful over time in contrast to adolescents not touched by parental death. Coping with parental death adversely impacted adolescents' interpersonal relations, posing a major obstacle to adolescents' developing a sense of belonging among peers. Adolescents in the Massachusetts study thought of themselves as being more mature than those peers who had not coped with the death of a parent.

The authors of both research projects reported that consistent, effective parenting greatly assisted bereaved adolescents to cope with their bereavement and subsequent negative events. The Arizona State University researchers operationalized positive parenting in terms of parental warmth and consistent discipline, reporting evidence that positive parenting provided a buffer against the onset of mental health difficulties. Girls, in particular, demonstrated positive outcomes to consistent, effective parenting; without such parenting, bereaved girls had notable problems handling negative life events.

Adolescent Bereavement Over Sibling Death

Scholarly research on adolescent bereavement began in the early 1980s, focusing initially on self-concept and emotions. For instance, the Offer Self-Image Questionnaire for Adolescents (OSIQ) was used to assess bereaved adolescents' self-concepts. On most subscales the bereaved adolescents' responses to the OSIQ are no different than the responses of normal teenagers; on the morals subscale, bereaved adolescents' responses were one standard deviation higher than the scores of normal teenagers, suggesting that coping with sibling bereavement had sensitized adolescents to develop a more mature understanding of moral quandaries. These findings led to conclusions that sibling bereavement may not adversely affect adolescents' growth in self-understanding but may actually impel growth in some arenas.

The extent of family communication about matters of significance and extent of emotional closeness to members of the family (termed *family coherency*) significantly differentiate bereaved siblings' recollections of their emotions in the first few months after the death and their current emotions about the death. Adolescents who characterized their families as having "greater coherency" said their emotional reactions in the first few months after the death were filled with confusion, guilt, loneliness, sadness, and fear. Over time open

discussions occurred within their families about their sibling's death; while they currently felt an enduring sadness, they had resolved their other emotional reactions and, in particular, felt no guilt or confusion about the death.

However, adolescents who said "less coherency" described their families said their initial emotional reactions to their siblings' deaths were primarily feelings of anger and guilt; over time their confusion increased, as did their fear and loneliness, and their anger had not lessened. Families with greater coherency provided adolescents a network for working through problems over the death by using the family as a communication and emotional resource. Less coherency left bereaved adolescents and their family members isolated from one another and ruled out the family as a resource for addressing practical issues, such as the reasons the sibling died, and personal issues, such as feelings elicited by the death.

A valid, reliable instrument titled the Hogan Sibling Inventory of Bereavement (HSIB) is useful for gathering data on adolescent sibling bereavement; this instrument provides information about grief and about self-concept. When mothers and fathers were asked to complete the HSIB as they thought their adolescent had completed it and the responses of mothers, fathers, and adolescents were analyzed, it was clear that mothers and fathers had significantly different perceptions of their adolescents: The mothers considered their adolescents' grief to be more problematic than did the fathers, and the mothers believed their adolescents' self-concepts were more mature than did the fathers. The parents' HSIB scores were compared to the scores of the adolescents, and against all expectations found in the literature the fathers' and the adolescents' scores were in substantial agreement, whereas the mothers' scores differed significantly from what the adolescents reported.

Adolescents' HSIB scores of self-concept and of bereavement intensity show an inverse relationship. In short, over time adolescents with low self-concept scores had high bereavement intensity scores, and adolescents with high self-concept scores had low bereavement intensity scores. The inference is that adolescents with low self-concept are at risk of long-term negative consequences. This finding has even greater salience when juxtaposed with the expectation that adolescents will develop a sense of mastery and control, suggesting long-term issues with persistence and confidence as bereaved siblings with low self-concept enter adulthood.

David E. Balk

See also Accidental Death; Gender and Death; Grief and Bereavement Counseling; Homicide; Life Cycle and Death; Make-A-Wish Foundation; Suicide

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Adulthood and Death

Death is an integral part of life throughout adulthood. Psychologist Carl Jung proposed that adult development is characterized by a process whereby one moves from the omnipotence and immortality

of young adulthood to the confrontation of physical aging and loss of loved ones characteristic of middle and late adulthood. The leading causes of death, as well as the most common types of losses experienced, are defining features of each stage of adulthood.

Young Adulthood

Leading Causes of Death During Young Adulthood

Young adults benefit from excellent physical health and low rates of life-threatening illnesses. All combined, accidents such as falls, motor vehicle accidents, and poisonings are the leading cause of death during early adulthood. Homicide and suicide follow accidental death in frequency, with homicide being more common among young adults under age 25. Homicide is also the leading cause of death among young black men living in urban settings. Suicide is the second leading cause of death among 25- to 34-year-olds and the third leading cause of death among 15- to 24-year-olds. Cancer and heart disease are the fourth and fifth most common causes of death in young adults, respectively, and increase in frequency during the later years of young adulthood. Finally, HIV is the leading cause of death among young adults over the age of 25 who live in cities with populations of 100,000, is the fourth leading cause of death among black men, and is the third leading cause of death among young black women.

Common Deaths Grieved by Young Adults

Death of Grandparents

The death of grandparents is often the first significant death that young adults face, and although the loss of a grandparent may be quite painful, grandparent deaths are often anticipated and do not seem out of the natural order of events. Additionally, their deaths do not usually cause upheaval in carrying out the daily routines or normative developmental tasks of most young adults.

Death of a Child

The literature describes the death of a child as the most difficult and painful death to grieve because it violates all assumptions about the natural order of life and death; namely, that parents should not outlive their children. When a child dies, a parent loses not only their child but also their hopes and dreams for the future and often their sense of a just world. Starting a family is one of the primary developmental tasks of young adults, and even though the average age at which women bear children has increased over the past 3 decades in the United States, most babies are born to young adults. Accordingly, most early childhood deaths affect young parents at a time they are most invulnerable and have had little experience coping with death, particularly one judged to be so untimely and unfair.

Prenatal Death

Of the approximately 6 million pregnancies that occur each year in the United States, 2 million end in pregnancy loss as a result of miscarriage, ectopic pregnancies, molar pregnancies, stillbirth, and abortion. Although the medical recovery from the loss of a pregnancy is usually rapid and uneventful, the psychological effects can be traumatic. Unfortunately, the death of a preterm baby is often minimized and not adequately validated as a significant and profound loss.

One third of all abortions occur among women in their early 20s. Despite the voluntary nature of abortion, researchers report many women experience significant, and sometimes lifelong, abortion-related grief.

Death of Friends

Six to 10 million Americans are affected each year by the death of a friend. While all adults experience the death of friends, young adults have had less experience with death overall and their friends are vitally important sources of social support. Delaying marriage until the late 20s to mid-30s has increased reliance on friends while one forges an independent adult life. Perhaps because of their lack of death-related experience and a sense of immortality, young adults are at risk for experiencing complicated grief following the loss of a friend, particularly when the death is unanticipated, violent, or both. Moreover, friends are frequently overlooked as legitimate grievers because society often acknowledges and validates only the grief of families.

Middle Adulthood

Leading Causes of Death During Middle Adulthood

Degenerative diseases account for the majority of deaths during middle age. Heart disease and cancer combined account for roughly 60% of all deaths during middle adulthood. Accidents, chronic obstructive pulmonary diseases, liver disease, and stroke also are common causes of death among middle-aged adults.

Common Deaths Experienced by Middle-Aged Adults

Death of Parents

One of the most defining events of adulthood is the death of parents. Due to increased life spans, most middle-aged children now experience the death of their mothers between the ages of 45 and 64 and the death of their fathers between ages 35 and 54. Death of an elderly parent is viewed by many as normal, to be expected. Yet, even if parental death is predictable, most adult children are not prepared for it and often describe themselves as feeling orphaned. Furthermore, regardless of the historical nature of the parent–child relationship, the death of one's parents removes the buffer that shields them from death. Ultimately, the illusion of personal immortality so common during young adulthood is shattered by parental death, and the midlife developmental task of coming to terms with one's personal mortality commences.

Death of Spouse

Spousal death is less common during middle age than late adulthood, but middle-aged widows and widowers are often at greater risk of physical, social, and emotional problems, as well as higher mortality than their nonwidowed elderly counterparts. This heightened risk of negative outcomes may be attributed to the fact that middle-aged widowers often lack the level of social support experienced by elderly widowers who are likely to know more widows and widowers. And because of increased delays in childbearing in the United States in particular, many middle-aged widowers struggle with childrearing responsibilities, full-time work, singlehood, and often a significant decline in standard of living, all while trying to cope with the death of their life partner.

Late Adulthood

The elderly comprise less than 25% of the U.S. population but account for approximately 75% of all deaths recorded annually. Although fear of death declines with age, deaths of loved ones occur much more frequently in late adulthood, resulting in cumulative grief. Each loss serves as a poignant reminder of one's mortality and the inevitable deaths of more loved ones in the future.

The leading causes of death among the elderly are chronic diseases: heart disease, cancer, stroke, obstructive pulmonary diseases, and dementias as well as acute conditions such as pneumonia and influenza. Suicide is another cause of death among the elderly. In fact, the suicide attempt/completion rate of 4:1 is higher than the attempt/completion rate of 8:1 to 15:1 for younger age groups, resulting in a rate of suicide that is higher for white men over the age of 65 than for any other age group, including teenagers.

Common Deaths Experienced by Elders

Death of Spouse

More than 50% of all women over the age of 55 and at least 70% over the age of 75 are widowed. Although widows outnumber widowers by a 6:1 ratio, most widowers remarry, particularly those under the age of 75; many elderly widows do not. Again, the death of a spouse constitutes the loss of one's primary friend, companion, and lover, as well as secondary losses that include income, social invitations and connections, and assistance with household tasks. However, elderly spouses often provide essential health and physical support for their partners, and when they die, the surviving spouse may not be able to live independently. Finally, although depression and anxiety often increase following the death of a spouse, spousal caregivers may also experience a sense of relief and freedom following the death of their elderly spouse.

Death of an Adult Child

As average life expectancy has increased over the past century, so too has the likelihood of an elder experiencing the death of an adult child. The

death of a child is cause for disruption of the natural order of life. For elders there is the added loss of essential social, emotional, and physical support even as one's own health declines. Many elders expect that their adult children will help care for them in their old age and if the child dies, elders face pain and grief over the loss of their child as well as experiencing fear for their own future care.

Death of Siblings

Siblings are the keepers of one's history. Indeed, siblings have the potential to know and share one's entire life story from birth to old age. Even if one has not been emotionally and/or physically close to a sibling who dies, there is still the loss of a constant with the sibling's death. Such loss is profound and omnipresent and yet often goes unrecognized by others.

Death of Friends

Friendships in old age are related to life satisfaction, quality well-being, and life enhancement; many elders view their friends as their most important confidants. Accordingly, the loss of friends during old age poses a significant challenge to the relational and emotional aspects of elders' lives. The death of friends and family members may result in increased social isolation and lack of needed support. However, unlike the disenfranchising experience that many younger and middle-aged adults face when a friend dies, because some friendships in old age span decades, elder friends are often afforded significant consideration by the deceased friend's family.

Finally, adults must learn to cope with necessary losses. Coping with the death of loved ones, as well as contemplating and learning to live with one's own finitude, remain core developmental adulthood tasks.

Brenda Moretta Guerrero

See also Aging, the Elderly, and Death; Friends, Impact of Death of; Life Cycle and Death; Life Review

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Advance Directives

See Living Wills and Advance Directives

African Beliefs and Traditions

Most African people regard death with great reverence and awe. Researchers and practitioners in death care have observed that in the study of cross-cultural differences, considerations of culture/subculture, spirituality/religion, and social class are important factors that influence attitudes, beliefs, and values in death, dying, and funeral rites. Cross-cultural research reports that factors such as social class and spirituality are important in explaining the range and diversity of beliefs, values, and practices observed among African people.

Africa is a vast continent with considerable diversity among its people. A number of distinctive cultural traditions concerning births and deaths have been observed across its various subcultures, societies, and tribes. Many Africans observe and identify with a variety of spiritual beliefs and many of their attitudes, beliefs, and values about life and death are aligned with their spiritual beliefs. For example, although many West Africans subscribe to elaborate funerals, West African Muslims have

characteristic beliefs about death care, postmortems, and preparation of remains, including simple funerals with a dignified burial. In addition, the socioeconomic status is of significant influence in that the wealthy are more likely to embalm and invest in metal caskets while the less affluent are more likely to forgo embalming and use simple wood carved caskets. Such differences exist among many African tribes.

African Views on the Origin of Death

Like most people, Africans have many enduring curiosities and beliefs about the origin of death. One such African myth regards death as a spirit that grants a "gift of escape" from the suffering of the physical world. Another of the oldest and most enduring accounts about the origin of death is referenced in the ancient folklore of the Asante of West Africa. According to folklore, there was a time when people experiencing death petitioned God to stop death. The request was granted, and for the next 3 years no one died and no children were born. The people again petitioned God to have children even if it also meant accepting death. This ancient African folklore illustrates the African worldview that life and death are complementary—a view of life and death as cyclical with death viewed as a part of this cycle.

African death superstitions evolve into practices and customs based on insecurities and fears about death. One African tribe has a custom of removing the dead body through a hole in the wall of the house instead of the door. This is done to make it difficult for the dead person's spirit to remember and find its way back to haunt and disturb the family. Likewise, many enduring intricate African funeral rites are believed to be essential to honor and to place loved ones at rest. According to African beliefs, by executing these funeral rites the survivors minimize the chances of wandering spirits returning to disturb those left behind. Many such funeral customs and practices of death care are based on mythology and superstition about death.

But despite the considerable diversity among African people, some commonalities and distinctive cultural markers can be identified as these are based on shared attitudes toward death, dying, and funeral rites.

Death as a Part of Life

The ancient Asante folklore about the origin of death reflects a belief about death—namely that death is a part of the natural rhythm of life. One enduring belief is that the death of an elder within a family and community is followed with a birth. The cyclical view of life regards death as a natural part of life and that each birth constitutes a renewal of life and community. Consistent with this belief, the ancient ritual of passing babies over the casket of a deceased elder is a way of honoring the elder and also honoring the life and death connection that is so important to family and community.

In many African societies and tribes, the symbol of the circle is a recurring theme in art. Ritualistic symbolism in sacred art and other artifacts represents renewal. Among the Asante the symbol of the Ankh is a large circle with a small cross that symbolizes life, fertility, and the renewal of life. The circle is also common in the design and representation of many other similar artifacts that are associated with life and well-being, referred to as fetishes or ancestor figures. This symbol closely resembles a similar artifact observed to exist in ancient Egyptian culture representing life, fertility, and the renewal of life.

Belief in the Afterlife

In Africa there is a commonly shared belief in a life following death. Accordingly, the individual dies and joins the community of ancestors, thereafter residing in the spirit world and afterlife. Many African cultural artifacts, such as art, music, sayings, superstitions, and traditions, reflect this belief in the numerous references made to joining loved ones who have died and progressed to the afterlife. For many people of African descent, the reference to funerals as "homegoing services" exemplifies more than disposal of the remains; such rites serve as a celebration of the deceased passing on to the spirit world. Africans residing in the Sea Islands, Angola, and Sierra Leone share these beliefs.

Similarly, it is common among many people of African descent to speak of the dying person "making his or her transition" from the material world to the spirit world and afterlife. Thus, religious orientations influence beliefs about heaven and hell

and how one's earthly existence influences the consequences or rewards and punishment in the afterlife and ideas relating to reincarnation. The Nguni of South Africa routinely slaughter an ox as a part of their funeral custom. The Nguni then refer to the ox as "the returning ox," which is believed to play an important role in accompanying the deceased in the journey home in the afterlife.

Funerals as "Primary Rituals"

In the African religious worldview, death represents a transitional stage in life that requires a passage rite. West Africans especially are noted for their thorough execution of funerals. Many West African tribes, such as the Asante, Ga, Fanti, and the Akan, have funeral rites and practices that are traceable back for thousands of years. Many of these African subgroups invest considerable amounts of resources and energy in the execution of funeral rites for the dead. Among the West African Asante, for example, funerals are elaborate and command more investments than most other rites such as weddings. The more esteemed and higher the individual's social status is within the community, the more elaborate and extensive the funeral rites will be.

According to African tradition, the immediate survivors have the primary responsibility and duty to assure that loved ones are given a "correct" funeral, incorporating aspects of the cultural and spiritual traditions to ensure the spirit of the loved one may find its resting place in the afterlife. Many Africans believe that if a funeral is conducted properly the loved one's spirit may wander, thereby causing misery and suffering for the survivors. Increasingly there has evolved an expectation among many West Africans to hold elaborate and often costly funerals leading in turn to social pressure to conform. Therefore, these expectations evolve into customary practices and ultimately traditions in many parts of African societies including African people who migrate. To not respond to this expectation is to experience feelings of shame and be viewed with dishonor.

Communal Grieving

Most African funerals are communal, with considerable value placed on community participation. In addition to family members, other community members often are involved in funeral rites and it is customary for them to express condolences. According to the cultural tradition of the West African Asante, for example, a strong sense of obligation generates condolences and financial contributions to assist in paying for funeral expenses. Indeed, many activities such as the sit-up, wake, and funeral represent social occasions that reaffirm social relations, solidarity, and group identity.

Ground Burials for Final Disposition

Most Africans prefer ground burial over other types of final disposition of human remains, but considerable variation exists in this practice, including the positioning of the grave, the individuals who participate in the preparations for burials, and the cost for burial ceremonies and the grave site. But there is also an increasing acceptance of cremation and other forms of final disposition in response to rising economic costs of traditional funerals. In addition, Muslim Africans believe in the simplicity of funerals and burials, which are primarily handled by males to include a simple grave with the remains simply placed in the ground facing east toward Mecca.

Many regional and ecological differences among African people also are impacting the rates of dying, death, and death care. In regions of East and South Africa, the realities of political instability and ethnic strife fuel ethnic conflict and soaring death rates. In addition, the rates of HIV/AIDS–related deaths are decimating many regions in epidemic proportion; such loss of human life burdens the survivors and the young with untold challenges. It remains to be seen whether the effects of the AIDS epidemic will also impact unique cultural aspects of dying, death, and bereavement in these regions.

Ronald K. Barrett

See also Funerals and Funeralization in Cross-Cultural Perspective; Funerals and Funeralization in Major Religious Traditions; Grief, Bereavement, and Mourning in Cross-Cultural Perspective; Race and Death; Social Functions of Death, Cross-Cultural Perspectives

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After-Death Communication

After-death communication (ADC) is a spontaneous experience among people who have a feeling or sense of contact with a deceased person. ADCs are common and occur across culture, race, age, socioeconomic status, educational level, and religious belief. In the study of death and the human experience, reports of ADCs naturally occur. When they feel safe in doing so, people spontaneously share their ADC experiences when talking about their relationships with their deceased loved ones, their grieving process, or both. The study of ADCs falls under several disciplines: paranormal psychology, grief and bereavement therapy, religion and spirituality, anthropology, sociology, philosophy, and medicine. ADCs are frequently reported as being comforting, pleasant, and life-enhancing. Some people have described their experiences as unpleasant or frightening; however, the unpleasantness is thought to be a result of people having difficulty integrating these experiences into their lives. Despite the common nature of ADCs, they go largely underreported due to percipients' fear of being ridiculed or being thought insane. In the following discussion the topics focus on the history, incidence, characteristics, and types of ADCs.

History

Encounters with the deceased or ADCs have been reported in many cultures. Formal research dates back as early as the 1890s with the Census of Hallucinations conducted by the Society for Psychical Research. Researchers from the Society for Psychical Research found that hallucinations of deceased persons were common among the sane. Researchers in the field of paranormal psychology have typically led the way in the exploration of ADC as a common, normal human experience. At the time of the census study, these experiences were called "hallucinations of the sane" to indicate how encounters with the deceased were common among the general population. Also inherent in the census study was the assumption that these types of experiences are not merely a result of a yearning on the part of a grieving person; the ADC percipient may or may not be grieving. According to reports from the census study, some people actually had an encounter with a deceased person who was not known to them as being deceased. These ADCs are interesting because they debunk the theory that ADCs are just a result of bereaved people imagining they see their loved one out of desperation and intense longing. Since the census study was conducted, people have continued to report experiencing an ADC without knowledge of the deceased person's death.

During the 1960s and 1970s, researchers who studied widows and widowers began noticing the experience of "hallucinations" as a common characteristic of grief. Initially these experiences were thought to be a result of people's intense longing for the deceased and difficulty facing the reality of their loved one's death. However, it became clear that these experiences were beneficial and comforting for many of those grieving and that the people having them were very much in touch with reality. Many researchers and bereavement experts expressed surprise at such an experience occurring to people deemed psychologically stable and fully aware of the deceased's death. Later, as a result of

these spontaneous findings, researchers began inquiring into this phenomenon.

Since the Census of Hallucinations study in the 1890s, encounters with the deceased have been referred to as the following: hallucinations, illusions, apparitions, sense of presence, contact with the dead, postdeath contact, and others. Bill Guggenheim and Judy Guggenheim coined the term *after-death communication* in the 1980s. Over the course of 7 years, they conducted the ADC Project during which time more than 3,300 firsthand accounts of ADCs were collected through interviewing 2,000 people from the United States and Canada.

The 1980s and 1990s marked a transition time between researchers reporting contact with the deceased as a side note to inquiring about its frequency, characteristics, and benefits. In the 1980s, researchers included the question, "Have you ever felt as though you were really in touch with someone who died?" in their Multinational World Value Survey and found the experience common among people from many countries.

Incidence

Researchers from various fields have contributed roughly 35 studies addressing the occurrence of ADCs. Based on these studies, the incidence ranges from 2% to 100% of subjects having an ADC experience. Results from an American survey conducted in the 1980s indicated that 42% of the American adult population reported having contact with the dead, and 67% of the widowed population reported having the experience. In general, the incidence for the widowed population is higher than that of the general population. Researchers reported results from the Multinational World Value Study in which close to 20,000 people were surveyed from the United States, South Korea, and numerous countries in Western Europe. The incidence of ADCs ranged from 9% in Norway and Denmark to 41% in Iceland.

The incidence of ADCs is difficult to report given the variation in types of studies, the specific terms used to describe the experience, the exact question(s) asked, and the measurement of response. Given the synthesis of the studies, a conservative estimate of the incidence of ADCs is 45% of the general population reporting having had this experience. The actual incidence of occurrence could easily be higher than that figure given percipients' reticence to report these experiences, especially to helping professionals.

Characteristics

Many people have described ADCs as a spiritual experience, but ADCs have also occurred among those without strong religious or spiritual beliefs. Even among those who report having strong religious convictions, some report the experience as not fitting in with their religious beliefs. There seems to be an element of surprise in these experiences. Often people have recounted learning of information via the ADC they could not have otherwise known and that was later verified. Many self-proclaimed skeptics have written about their ADC experiences, and they tend to lend a sense of veracity to the phenomenon given their resistance to believing that such an experience can occur.

Those having ADCs typically report having the communication with a deceased friend or loved one. What seems to be the most common message in these experiences is that the deceased person is "okay." Often people report that during the ADC experience, the deceased person seems happy, healthy, and strong. Percipients report feeling relieved and encouraged by the message or interaction. Many have even reported being instructed by the deceased person to move on, forgive, heal current relationships, take care of those who are still alive, and possibly even to not give up. Some people have reported having an ADC experience when in the midst of contemplating suicide and described the experience as deterring them from acting on their suicidal urges. Others have reported having an ADC experience at precisely a time in which they needed safeguarding. In these ADCs for protection, people received warnings that helped protect them or their loved ones from motor vehicle accidents, house fires, undiagnosed health problems, harm from criminals, and other dangers.

Having ADCs are not always about communicating with a friend or loved one. Researchers describe how a group of emergency service workers experienced a sense of communication with fatal injury victims whom they had attended at death. These personnel were deemed to be psychologically sound as well as respected and experienced professionals in their field.

Types of ADCs

ADC experiences can occur as the following types: sensing a presence, hearing a voice, feeling a touch, smelling a fragrance, seeing an appearance, and having a dream ADC. Also common are ADCs of physical phenomena, including incidents such as lights being turned off and on, mechanical objects being activated, pictures and other objects being moved, and other similar events. Symbolic ADCs are another common type of ADC in which percipients report receiving some kind of sign that confirmed for them that their deceased loved one survived physical death. Butterflies are the most commonly reported ADC sign.

Also reported are shared ADCs in which two or more people have a similar experience with the deceased at the same time. Such shared ADCs are noted in numerous studies and most recently in the study on emergency service workers. There were reports of partners who were interviewed separately who recounted similar ADC experiences with the same deceased patient at the same time—neither had discussed the experience with the other.

Crisis ADCs in which percipients had a communication with, or visit from, the deceased when they had no knowledge of the deceased person's death and often no knowledge of the deceased person being ill or in danger also are noteworthy. In these reports, the notification of death after the ADC experience led percipients to believe they had really been in contact with the deceased. In many reports, the percipients noted the time and/or told someone about the experience, and often the time of death coincided with the percipient's time of experiencing the ADC.

Lastly, deathbed visions are common among the terminally ill who are close to death and who report communicating with those already deceased. Researchers who studied this phenomenon stringently controlled for other factors that may have contributed to hallucinatory experiences, such as medication and medical diagnosis or condition. Patients having deathbed visions were deemed to be in contact with reality and typically reported feeling comforted by their ADC experiences. Many people report having multiple experiences, experiencing a combination of types, and experiencing ADCs with more than one deceased person.

Conclusion

Most people report ADC experiences as being positive, healing, comforting, and/or life-changing. For some, the ADC experience actually saved their lives. Rarely people have reported unpleasant ADCs. Many experts believe an unpleasant experience is a result of percipients not knowing that ADCs are common and normal and, therefore, having difficulty integrating these experiences. People consistently have expressed relief when they heard ADCs were normal and common. It is likely that even those with unpleasant experiences could benefit from them if supported by people who understood the phenomenon. ADCs are thought to be underreported, particularly to helping professionals such as the clergy, psychotherapists, and medical personnel because of concerns about the potential reactions from these same professionals.

People who are in contact with reality and are well aware of the deceased person's death experience ADCs. They are aware that their experience may sound like a hallucination—this is a good indication that they are not actually having hallucinations associated with a mental disorder. They may need or want to talk about their experience, and when they do so, they need someone who is supportive and nonjudgmental and who can normalize their experience. Also, it is important to help people find their own meaning in their experiences rather than interpreting them for them. Many who have the experience hope to have one again, and often those who are grieving and learn about ADCs hope to have such an experience.

Jenny Streit-Horn

See also Ambiguous Loss and Unresolved Grief; Bereavement, Grief, and Mourning; Chronic Sorrow; Communicating With the Dead; Coping With the Loss of Loved Ones; Grief and Bereavement Counseling; Widows and Widowers

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Aging, the Elderly, and Death

With the longevity revolution, for the first time in history, death has become a province of the old. During the 20th century, life expectancy increased by two thirds in the developed world. Increasingly its members die upon the conclusion of full, completed lives; in the United States, nearly 8 in 10 deaths occur among those 65 and older. Although this would seem to be the cause for collective celebration, instead old age has become a social problem. Cultural thanatophobia, excessive fear of death, has become thoroughly interwoven with cultural gerontophobia, fear of growing old or fear of the elderly, the latter demonstrated by the multibillion-dollar cosmetic surgery industry to obscure the aging process.

The cultural consequences of this great demographic change are considerable. Sociologist Wilbert E. Moore observed how the increasing longevity of all classes in postindustrial societies has disrupted the centuries-old synchronization between the temporal order of social systems and the temporal order of biological humans. Our contemporary social problem orientation to old age and anxieties about death may exist, in part, because we now outlive the traditional lifespan "recipes" and no longer "know" how to grow old and die. Whereas the traditional liminal state between life and death occurred soon after death, it now precedes mortality; one can now be simultaneously alive biologically and yet be socially dead.

With the old replacing the young as the most death-prone age group, the elderly have become the cultural shock absorbers of death, society's "death lepers" as Arlie Hochschild called them in *The Unexpected Community*. Death was a province of the young in Puritan New England, where parents often sent their children away to the home of relatives or friends ostensibly as a method of discipline but perhaps in actuality as a way to prevent them from becoming too emotionally attached to their offspring. Analogously, similar distancing from the death-prone is evidenced when the old move to age-segregated communities and when families send their aging family members to nursing homes to be cared for by others. This logic is evident in one of the central social gerontology paradigms of the last third of the 20th century, disengagement theory, which portrays a mutual parting of the ways between society and its older population. From the perspective of those aware of their limited life and with diminished ego strength, social withdrawal accompanies self-preoccupations and weakening emotional investments in others. From the perspective of society, the deaths of the disengaged diminish the disruptiveness of their deaths. It has been argued that the retirement phase of the life cycle arose, in part, as a cultural death consolation.

The longevity revolution has also affected the logistics for security that older persons traditionally had to command the loyalty and services of family members during their enfeebled years: inheritance. With land decreasingly being the chief legacy asset of individuals and with the increasing number of years spent in retirement and the dramatic post-1960s inflation of goods and services, particularly in medical care, the majority of older Americans now outlive their savings.

Further, given the age-stratified nature of so many social roles in modern societies, where individuals are more likely to interact and befriend their age mates throughout the life cycle, the longevity revolution has also made the final life stage a period of continuous bereavement as one's peers

die off and funerals comprise a growing part of individuals' social life.

Cultural Meanings of Death

American society is said to be if not a death-denying culture then at least a death-defying one. Social progress is measured in terms of increases in life expectancy rates. The obsession with quantity of life is reflected in the media attention given to the superannuated. For years, Willard Scott of NBC's *Today* show would give happy birthdays to new centenarians. The world's oldest person receives international recognition and a Guinness World Record certificate. In 2002 the honors went to a 115-year-old Japanese woman who slept through her birthday celebrations. Apparently her circadian clock had wound down as she would sleep for 2 days and then would be awake for the following 2 days. Despite such observances, superlongevity does not seem to be the life goal for most. A 2005 ABC News poll found Americans on average would like to live to be 87 years old; only one quarter said that they'd like to live to 100 or older.

Perhaps the cultural emphasis given to the quantity rather than the quality of life is evidence of the weakening influence of religion and philosophy in mitigating death fears. When the status of the dead was revered the authority of the old often was guaranteed. As confidence in an afterlife wanes, so often does the influence of the aged. Further, with dramatic social change, individuals no longer even live with confidence that the values and principles upon which they had predicated their lives will survive them, let alone that they themselves will be remembered. Such emphasis on longevity coupled with the historically diminishing status of the elderly in a society that worships youth has produced a profound cultural contradiction that portends change.

With death so often connected with the elderly, for those not old the prospects of death have (with the exception of those serving in the military) largely been dropped from conscious consideration when planning for the future. For instance, those enlarging their families rarely consider the possibility of the wife dying in pregnancy. The drawing up of wills is postponed. And whereas up until the 19th century one would have been considered a fool if one had not purchased a gravesite and saved for one's funeral expenses by one's late teens and early 20s, nowadays such actions would be considered morbid and pathological.

How the Old Die

Physical anthropologists tell us that like most other mammals, our distant relatives rarely if ever lived beyond their reproductive years. One evolutionary explanation for old age among *Homo sapiens* holds that females who lived longer, but whose fertility was curtailed in later adult life, were more successful at rearing their last-born children and may have contributed to the reproductive success of their earlier children. But because of their diminished biological reserves, the elderly are more susceptible to environmental maladies and have become society's miner's canaries owing to their greater likelihood of dying during climatic extremes and social disorder.

Over the course of the past century the leading causes of death of older Americans have shifted to chronic, degenerative diseases that prolong the dying process. In 1900, their leading causes of death were influenza and pneumonia (the latter referred to as "the old man's friend"), tuberculosis, and diarrhea and enteritis; in 2002 the causes were heart disease, cancer, and stroke, which together accounted for 61% of all deaths. Increasing rates of Alzheimer's disease (a malady experienced by over one half of those 85 and older and, in 2002, the sixth leading cause of death for persons 65 and older) and other memory- and identity-destroying dementias are fundamentally shifting cultural death fears from premature to postmature death. Fewer than 2 in 10 older individuals are fully functional in their last year of life. To die postmaturely is to perish when one's death is not one's own. In addition, there has occurred a concordant shift from cultural fears of postmortem judgment to fears of the dying process, enhancing the cultural authority of medicine at the cost of religion.

The old often must die a series of symbolic minideaths before actually expiring. The life stage is a time of loss: the loss of one's spouse, friends, jobs, health, standard of living, civic roles, driver's license, and of future time. With many living into their 80s and 90s, it is no longer unusual to even outlive one's children in addition to one's peers. For the institutionalized elderly in hospitals or

long-term care facilities, wherein three quarters of deaths in the United States occur, there are the additional losses of independence and dignity. Studies have shown older persons fearing nursing home residency more than death itself.

Such losses produce the common experiences of loneliness, grief, despair, anxiety, helplessness, and rage. Without much future, old age is a time of reflection and reminiscences. This inwardness, coupled with the social and psychological disengagements often made from life, can supposedly diminish such losses as one's attachments to the things of this world are lessened. But not always. Depression is not uncommon, which in conjunction with social isolation heightens suicidal thoughts and actions.

Throughout much of the world, suicide rates are often the greatest within the oldest populations, particularly among males. Such data may well be understated given variability in how coroners classify their deaths and their failure to account for acts of passive suicide, such as refusal to take life-prolonging medications or food. In the United States, for instance, though individuals 65 and older comprise less than 13% of the population, they account for one in five suicides, with 80% of these committed by elderly males. The suicide rate of white males is particularly pronounced: Of those 85 and older, the rate is 6 times that of the general populace—and over 4½ times that of their black counterparts.

Legacy Work

With increasing survivals to an advanced old age, many reach a developmental stage of gero-transcendence, when individuals shift their focus from a materialistic worldview to one more cosmic and transcendental, increasing both life satisfaction and death acceptance. With mentally and physically healthier older years, coupled with decreasing ages at retirement, older individuals have greater time and resources to devote to their legacy work in order to achieve at least some form of symbolic immortality. Former President Jimmy Carter's work with Habitat for Humanity and for his center to promote human rights and alleviate suffering around the world is one example; the Betty Ford Center for the treatment of alcohol abuse is another.

Older persons are learning how to employ the new information technologies to demonstrate the wisdom that the years can bring. Breaking the cultural silence on matters of death fears and grief was the appearance of geriatric1927 on the popular video-sharing website YouTube in 2006, wherein loquacious British pensioner Peter Oakley (aka geriatric1927) shared his autobiography and end-of-life outlooks. Within a week his was the most subscribed user name on YouTube.

Michael Kearl

See also Causes of Death, Contemporary; Causes of Death, Historical Perspectives; Disengagement Theory; Quality of Life; Suicide; Symbolic Immortality

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Alcohol Use and Death

Alcohol is a potent substance, capable of quickly transforming a seemingly respectable and rational individual into a babbling fool. This power can have further consequences, both immediately and over the long term. Rapid drinking of distilled liquor can lead to death in less than 1 hour, sometimes in as little as 30 minutes. Alcohol use has been linked to the genesis of fatal illnesses and irreversible deterioration in nearly every major organ system of the human body. Rarely does a chronic heavy drinker live a full life course and, at best, suffers multiple disabilities. The idea that "alcohol kills" has been a theme in American culture since the early 19th century, surrounded by data that directly confirm this assertion as well as evidence that is deliberately interpreted to support it.

As part of nature, alcohol predates humanity. Ethanol is a natural product of decay of organic material, making its presence known in all human societies and making its total obliteration

impossible. Despite many attempts, Prohibition has proven difficult to impose permanently.

Nonetheless, societal alcohol use, relative to risk of premature death, is often seen as *playing with fire*. Diffusion of information about the potential of damage and death associated with drinking rarely has a significant impact on the targeted drinking behavior. When access to alcohol is forbidden, people go to great lengths to ensure a steady source of supply. Thus, the public policy expert is forced to observe that much pleasure and positive reinforcement accompanies alcohol use. Relief from stress is sought daily by many individuals and groups through the relaxing effects of drink. Social and sexually oriented interactions as well as business transactions among relative strangers flow more easily with the lubrication of alcohol.

Further, in terms of custom and tradition, there are at least two types of events, each sometimes involving death, when groups and communities facilitate disinhibition through alcohol consumption. These are (1) celebration of rites of passage when alcohol may be used to escalate meaning and (2) commemoration of historical events or time passages during which alcohol may be used to invest and deepen the meaning of the occasion.

Public policy rarely showcases alcohol's social benefits or its embeddedness in cultural practices. Indeed, nearly all social policy statements about alcohol are heavily loaded with implications of damage, disease, and death. Beyond well-publicized dangers, the use of beverage alcohol (ethanol) by humans is intimately intertwined with several different types of explanations of death and experiences related to deaths. These relationships are of multiple types and go well beyond common knowledge that it is *risky* to consume alcohol. This entry offers a review of alcohol, death, and social policy; alcohol and fatalities; ecological perspectives on alcohol and death; and death rituals linked to alcohol.

Alcohol, Death, and Social Policy

The roles of alcohol in death are reflected in the ambivalent attitudes held by Americans, most Western societies, and many other cultures toward alcohol consumption. In addition to the well-documented experiences in the United States, many other Western countries have experienced periods of national Prohibition of the manufacture and use of alcohol. When and where it has been enacted, nations' rationales for alcohol Prohibition have almost always carried strong themes that alcohol causes premature death among both users and bystanders who may not be users. These bystanders include children, who may be the targets of violence or the victims of neglect; pedestrian and vehicular passengers who are struck by drunken drivers; or members of the public who are simply in the wrong place at the wrong time when alcohol-fueled violence breaks out. Prohibition has always carried a strong death theme that has been difficult for its opponents to challenge.

National prohibition is the distinct exception rather than the rule. To the extent that Prohibition exists, it is targeted at specific segments of the population (youth), periods of time (prohibited sales on Sundays, certain hours of the night, election days), and locations (sales prohibited in some locations relative to distances from schools and houses of worship). While the Prohibition of drinking among youth has a strong theme of injury and death, this is not true for the time and location norms.

The source of societal ambivalence clearly lies in the cycles of change from societal protection to societal liberation vis-à-vis alcohol. Consider the sharply contrasting policy of protecting the public from use of a powerful and death-linked substance through Prohibition and the policy of permitting, facilitating, and encouraging alcohol use in a manner that the substance is de facto available to anyone at any time. One perspective is relatively dormant but definitely alive during periods when the opposite perspective is dominant. The opposing visions view government as key to protecting public safety and health and reducing premature death while also abhorring government infringement on individual responsibility and freedom of choice.

Alcohol and Fatalities

According to data released in 2006 by the National Institute on Drug Abuse, alcohol can be blamed for 100,000 deaths in the United States each year.

- 5% of all deaths from diseases of the circulatory system are attributed to alcohol.
- 15% of all deaths from diseases of the respiratory system are attributed to alcohol.

- 30% of all deaths from accidents caused by fire and flames are attributed to alcohol.
- 30% of all accidental drownings are attributed to alcohol.
- 40% of all deaths due to accidental falls are attributed to alcohol.
- 45% of all deaths in automobile accidents are attributed to alcohol.
- 60% of all homicides are attributed to alcohol.
- 30% of all suicides are attributed to alcohol.

Categories of Alcohol Use With "Causal Connections" to Death

This inventory reinforces the question of why a society permits its citizens access to this toxic substance. The foregoing list sets the stage for considering a number of problems in asserting causal linkages between alcohol and death.

At the top of the list are included deaths from cirrhosis of the liver, long believed to be a strongly correlated physical consequence of excessive drinking, as well as being a fatal disease. In fact, despite widespread public belief, there are numerous cases of cirrhosis in which decedents had consumed minimal alcohol during their lifetimes, and a much more vast number of cases of high levels of alcohol consumption for which there is little evidence of cirrhosis at the time of death. Respiratory illnesses are highly correlated with smoking behaviors, in turn associated with heavy drinking, but the specific etiological factor is difficult to discern. However, it is important to note that pathology is a well-developed science, and autopsy can often pinpoint specific etiology. The critical issue though is that the vast number of drinkers, who use the substance moderately, pass through their lives without a premature death attributable to alcohol.

The next category of deaths focuses on accidents. These evoke visions of the drunken person awakening and unable to escape due to the flames generated by dropping a burning cigarette, or the drunk stumbling off the end of the dock in the late night hours. Unlike the medical specialty of pathology, there is a paucity of readily available tools or techniques to discern whether the drinking was the cause of death or simply an element that was present at some level when death occurred. Recognizing that there are extensive forensic techniques available to conduct social-psychological autopsies, these are expensive and rarely come into play unless there is some exceptional circumstance present, such as someone with a vested involvement in the death event.

The frequency with which alcohol as a causal agent is accepted without calling for a social-psychological autopsy is a demonstration of the extent to which alcohol's potent agency is embedded into Western culture. Looked at another way, isolated death events seem much more readily understood in terms of risky individual behaviors rather than risky environmental circumstances. In the two hypothetical cases described in the previous paragraph, it is obvious that a multitude of environmental conditions could have been the cause of death, such as the flammability of the sleeping quarters or access to exits. Likewise, poor lighting or the absence of a locked gate on a dock could have explained the drowning death. Given the sustained omnipresence within American culture of the Prohibition-based vision of Demon Alcohol, these are not the preferred explanations in the absence of an investigation.

The drunk driver is the most prominent in generating an institutionalized symbol in American culture of death caused directly by alcohol. Substantial societal energies are directed toward detecting persons who are driving with a specific blood alcohol content (typically .08%) that is defined as a physiological condition that impairs the ability to drive.

Ecological Perspectives on Alcohol and Death

One way to look at the alcohol linkage to death on the highways is an *ecological* perspective. Five ingredients are present when a drinking driver casualty occurs: alcohol in bloodstream + driver + automobile + highway + crash event. Testing for alcohol in the bloodstream and/or other evidence of alcohol consumption is at the forefront of the investigation and is usually the only dimension of the investigation. If alcohol is found to be present at the .08 level or higher, it is typically concluded that it was the *cause* of the event. When the driver is under 21 years of age, any evidence of alcohol consumption may be attributed as the cause of the accident and thus as the cause of the death.

The alcohol-as-cause explanation takes precedence over other possible causal explanations that

may not be considered. Clearly there is a ready cultural niche within which to place the individual: drunk-driver-as-killer. However, it is clear that other conditions affecting the driver could have "caused" the accident, such as lack of sleep, physical exhaustion, anger, emotional preoccupations, or the simple inability to drive a car. Likewise, unless blatantly obvious conditions are observed, defects in the physical functioning of the automobile itself are not considered as a possible cause of the accident. Similarly, although sometimes considered as a contributing factor, highway conditions are rarely, if ever, attributed as a primary cause of an accident when alcohol is found to be present.

This stands as an example of social processes directing the definition of cause and blame; in this case alcohol is the cause and the drinking driver is to be blamed. Each of the alternative explanations challenges social interests. Police and other control agents have simple measurement instruments to assess blood alcohol content, even though there is clear evidence that not all drivers are impaired when their blood alcohol is at the .08% level. There are no measurement devices or accepted standards to indicate inadequate sleep or emotional impairment. While urine testing is a possible indicator of drug use that may have occurred as long ago as 30 days, it has not yet been implemented in testing for impaired driving. Measurement of the ability to drive is determined by written and driving tests, which never involve a testing official supervising a candidate's driving at a speed limit of 70 miles per hour on a freeway in the dark.

To demonstrate how alcohol use has grown in dominance as a necessary and sufficient condition for explaining highway fatalities, the eclipse of mandatory vehicle inspection is worth examining. Whereas inspection of vehicles for their safety is mandatory in some jurisdictions, it has been abandoned in many others. In metropolitan Atlanta, Georgia, for example, mandatory safety inspections of vehicles were abandoned many years ago. To obtain a vehicle license, the condition of tires, steering mechanisms, brakes, and other safety devices that are vital parts of automobiles are not subject to any scrutiny. Ironically, other considerations with a sociopolitical tinge have ascended in priority: today in Atlanta, drivers may be fined and their vehicles impounded for lacking evidence that the vehicles meet carbon emission standards.

Finally, police and other public officials stand as both judge and jury when it comes to evaluating the possible role that road conditions may play in traffic deaths where alcohol is readily available as the causal culprit. Few public officials or their subordinates stand ready to impugn themselves as agents of death by maintaining unsafe highways.

Alcohol and Lethal Violence

Alcohol also is thought to be a powerful agent in many cases involving homicide. Within American history, the linkage between lethal violence and alcohol can be traced to the Temperance movement. Focusing upon the incredible monstrous power of its characterization of "King Alcohol," Temperance literature portrayed drinkers transfigured from calm and reasonable individuals into irrational killers. The ultimate tragedy was the drunken father coming home and assaulting his family, leading to the death of a child or a spouse. The peculiar causal influence of drinking and the murderous behavior were sometimes portrayed in an epilogue where the sobered father is shown in deep grief and remorse over his actions.

The alcohol and violence linkage has at least two forms: first, where it completely alters the nature of individuals and leads them to behaviors totally outside their *character,* or second, where drinking fully unleashes partially contained violent tendencies in other individuals with a history of trouble. There is, however, little debate over the alcohol–violence linkage in the criminological literature, although the methodological problems of establishing causal directions are well recognized.

In the current social climate in which there have been backlashes against the level of imprisonment in America, the prerelease treatment of prisoners with drug and alcohol addictions is projected to have a major impact on their recidivism. This supposed liberal policy embeds the assumption that these persons' alcohol and drug use made a direct and powerful contribution to the crimes that led to their imprisonment, possibly ignoring other remedies that might reduce recidivism.

Challenges to the validity of the alcohol and fatal crime link are similar to that of the alcohol and highway fatality linkage. Other factors that could have precipitated the crime tend to be ignored if alcohol (or other drugs) is visibly present. This pattern of

causal thinking is often strongly encouraged by the perpetrators themselves, and it continues to be supported when prisoners are asked to reflect upon the causes of the fatalities in which they were involved. It should be no surprise that prisoners would concur that their substance consumption rather than their lack of self-control resulted in their crimes. A more sophisticated vision of alcohol's role in criminal fatalities comes from the relatively new conception of crime "hot spots," where violent crime rates are exceptionally high and where alcohol and drug outlets are central to the environment.

Finally, an innovative addition to this area of explanation is consideration of the alcohol or drug use of the victim in the setting of criminal violence. A drunken victim can be posed in several ways: the victim's alcohol-fueled disinhibition leading to behavior that precipitates a violent act; the victim being impaired by alcohol and thus unable to properly engage in safety-seeking behavior; or the victim actually entering the situation with the intention of being the "villain" but failing to achieve this goal due to alcohol-related impairment.

Suicide

A final category of fatal outcomes linked to alcohol is suicide. Given the manner in which chronic excessive drinking can create collateral and progressive physiological and psychological damages, the behavior of untreated alcoholism is often conceptualized as *slow suicide* or as death-seeking behavior. Autopsies commonly reveal the presence of excessive alcohol intake accompanying the use of other substances, suggesting that the alcohol use either generated the *nerve* to take the other poisons or that its use blunted the effects of the other substances. Likewise, those attempting suicide by means other than substance ingestion may use alcohol to create the courage the commit the fatal act.

Despite its dramatic role as a seductive killer of innocents, alcohol often leaves behind mystery when it is present at a suicide. Sometimes it appears that the suicide may have been an accident, with the individual seeking relief of some sort (but not death) through the effect of some other drug, with the accompanying dose of alcohol leading to an unexpected and unintended toxicity. Alcohol's presence at a suicide may also involve incomplete notes, or a telephone off the hook, suggesting that the individual did not adequately anticipate the effects of alcohol in whatever combination with other substances, and ended his or her life as the victim of an accident.

Alcohol, Death Dramas, and Death Rituals

Alcohol has roles to play both before and after death. In many cultural settings, there is a social license to drink offered to the mourners of the deceased. While Irish Americans have perfected these rituals in manners recorded in fiction and drama, such practices are also found among many eastern Europeans. Drinking during the wake may be suspended for a brief period for the funeral and burial, but then is resumed with vigor at the post-funeral luncheon or banquet. Across different cultural settings, these drinking events have a fascinating double-pronged rationalization: Alcohol is to assuage the grief of the mourners, but it is also used to celebrate the entry of the deceased into the life beyond, free from the chains and burdens of earthly existence.

The diversity in the presence of alcohol at death ceremonies and its patterns of use have been explored cross-culturally by anthropologists. Archeologists have revealed the presence of alcohol in many burial grounds and tombs, suggesting that survivors desired that their beloved and/or revered departed would have the opportunity to drink in a new existence. In recent years, a similar ritual reportedly was observed by the children of the famous singer and drinker Frank Sinatra, who added cigarettes and Tennessee whiskey to his casket before it was closed.

Finally, we have those isolated but dramatic events where alcohol plays into a "death drama." Relatively little analysis has been provided of the role of alcohol in the military, and even during World War II, when a literal swarm of behavioral scientists studied their peers in uniform, nothing in these writers' extensive documentation of soldiers' behavior was offered about the role of alcohol. Very early accounts indicate that ancient warriors readily consumed alcohol to augment their bravery and that such behavior transformed Alexander the Great into a distinctively alcohol-dependent individual. The Southeast Asian conflict of the 1960s and 1970s was marked by great excesses of alcohol and drug consumption. While the current war in Iraq is

generating large numbers of veterans with severe alcohol problems and other disorders, the presence of alcohol in the death-threatening circumstances of battle and guerilla terror escapes discussion.

Paul M. Roman and Lauren A. O'Brien

See also Causes of Death, Contemporary; Drug Use and Abuse; Homicide; Mortality Rates, U.S.; Suicide

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Altruistic Suicide

In modern medicine, suicide is largely understood as an outcome of depression, an act resulting from a trajectory of mental illness spiraling downward into that profound hopelessness from which the victim cannot recover: Killing oneself comes to be seen by the victim as the only way to relieve intense psychic pain, or the only way out of an intolerable situation. The final act of suicide can sometimes be delayed or prevented by the use of psychotherapy, drugs, and/or emergency hospitalization; long-term prevention strategies for repeat episodes of suicidality include treatment of the underlying illness and continuing surveillance for warning signals of self-destruction. This understanding of suicide casts it as largely nonvoluntary and self-referential, a human tragedy frequently stigmatized and always to be prevented. In contrast, the focus in this entry is on altruistic suicide, the taking of one's own life for the interests of others. Altruistic suicide may be undertaken for the sake of family members or loved ones, for cherished institutions, for communities, for ideas and principles, for society in general, to serve divinity, or for a number of other reasons.

Altruistic Suicide

Among the classic specimen cases of altruistic suicide is the jet fighter pilot, who, when his plane fails, crashes it with himself still in it into a field, in order to avoid a crowded schoolyard. He does so knowingly and deliberately, and he does it to avoid killing the children, even at the cost of his own life. It is a clear case of altruism, the sacrifice of one's own interests to promote those of others. Of course, such a death is not normally labeled "suicide" but "self-sacrifice," "heroism," or some other adulatory term. Nevertheless, the pilot did kill himself by refusing to eject from his crashing plane.

Is this a case of altruistic suicide? This first question can be interpreted as a conceptual one: Given the highly negative connotations of the term *suicide* in English but the positive appraisal of altruistic acts, is it coherent to speak of "altruistic suicide" at all?

A second question concerning the possibility of altruistic suicide is a psychological one: Is it possible for an individual to both knowingly and deliberately cause her own death in a way that focuses primarily on the interests of others, rather than on her own situation and consequences to herself? Is genuine altruism possible at all, or are all our acts self-interested? Thus it might be said of figures who give the appearance of altruistic suicide that they act primarily for the rewards of (posthumous) reputation or religious afterlife: Lucretia, who preserves her sexual fidelity and thus her husband's honor even at the expense of her life; the many Stoic Roman generals who fell on their swords rather than risk defeat or, like Cato, to preserve their honor as well as their people; the legendary Buddhist figure Sakyamuni, who allowed his body to be eaten by a starving tigress; or elderly persons in some traditional Inuit and African cultures, who cooperated in social practices such as being dropped through a hole in the ice or buried alive in order to protect their communities from the burden of caring for them. Tradition counts Lucretia, Cato, Sakyamuni, and to some degree the elderly who cooperated with senicide practices as people extraordinarily attuned to the interests of others; however, motivation may be difficult to assess in widely divergent or historical cultures.

Familiar contemporary everyday examples of what might be said to be altruistic suicide include the mother who leaps onto the train tracks in order to push her child to safety, the soldier who falls onto the grenade to protect his buddies, and similar cases. These cases raise a third question concerning the possibility of altruistic suicide: Is the urgency of these cases so great as to make the notion of "knowing and voluntary" action irrelevant, and are these simply spontaneous, immediate reactions without clear thought as to the outcome?

Yet there are other cases in which there is evidence of long-term, deliberate, reflective attention to both the action of killing oneself and producing beneficial effects for others, the essential feature of altruism: the self-immolation of Buddhist monks and nuns as protests during the Vietnam War, the Japanese kamikaze fighter pilots during World War II, and the highly premeditated and trained jihad acts of suicide bombers in Sri Lanka, Iraq, Pakistan, and many other areas of conflict (called martyrs rather than suicide bombers by their defenders). Some may be acting primarily for posthumous reputation or afterlife reward, but there is clear evidence in many such cases, recorded for instance in letters or videos made prior to a kamikaze flight or a jihadi suicide attack, both of premeditation and of action for a cause involving the interests of one's community.

Is Altruistic Suicide Possible?

Is altruistic suicide possible? Motivational skeptics would deny that any truly altruistic act is possible and thus that truly altruistic suicide is not possible; those theorists who accept the possibility of altruism may answer yes, though it is then still necessary to consider whether *suicide* as distinct from other human acts can be altruistic. Sociologist Émile Durkheim argued that some types of suicide are founded in sociological structures such as conformance to societal expectations in a society in which individuals are highly integrated; sociobiologists such as E. O. Wilson see biological patterns favoring kin selection, such as the self-sacrifice of a member of a group to save the others, that enhance the success of one's genes despite the cost of one's life, and hence not really altruistic at all. A typology of altruism might include evolutionary or biological altruism, personal or psychological altruism, reciprocal altruism (one's altruistic activity conditioned on the recipient's behaving altruistically in return), spiritual altruism, social altruism (prosocial behavior), economic altruism (economic models for altruistic economic transactions, mostly within the family), medical altruism (the benefits to one's own health or self-esteem of altruistic behavior toward others), and various other mixed forms. A more specific typology of altruism with relevance to suicide could be constructed not only with reference to these categories but with reference to the degree of intermixture of egoist and altruist motivation in the types mentioned above: Purely altruistic suicide requires acting solely in the interests of another, contrary to one's own interests; moderately altruistic suicide involves acting in the perceived interests of both oneself and another; and weakly altruistic suicide largely serves one's own interests but is also intended in some degree to benefit others.

What Proportion of Cases of Suicide Are Altruistic?

Even assuming that partially or wholly altruistic suicide is possible, conceptual problems make it impossible to ask what proportion of suicides are altruistic as a straightforward empirical question. However, it is possible to consider a range of potential cases in which altruistic motivation might appear to be central.

Consider, for instance, the elderly person of moderate means, now detecting the early symptoms of Alzheimer's disease. A decade or more of progressive deterioration will mean substantial care needs: The patient will gradually lose short-term memory, fail to recognize caregivers and family members, and typically sustain financial costs for custodial care estimated in 2008 at perhaps $100,000 a year. Would a suicide intended to preclude these burdens for others count as altruistic? A part of the motivation in such cases may be to avoid the perceived indignities of late-stage Alzheimer's disease—spoon-feeding, diapering, and constant surveillance—but might some or much of it be altruistic, to avoid the burdens of care that fall on family members or, especially where adequate health insurance is not available, expenses that bankrupt the family and mean no financial legacy can be left for descendants? Inasmuch as suicide is not openly socially accepted on grounds such as protecting one's family from financial burdens, it is difficult to know how many such cases now occur or might occur under other cultural attitudes or social expectations.

Should Altruistic Suicide Be Socially Tolerated and/or Legally Permitted?

Consider the issue of altruistic suicide in terminal illness. Most physician-assisted suicide in jurisdictions where it is legal, particularly Oregon and the Netherlands, is associated with cancer, about 80% in each, forgoing a relatively brief period of life, estimated in the Netherlands as on average about 3.3 weeks. Are such "suicides," or occasions of aid-in-dying, egoist in character, sought by the patient to avoid pain or suffering in the final period of dying; or are some or many at least partly chosen to spare family members or one's community or society the emotional, social, and financial burdens of care?

If the latter, should they be socially tolerated? Legally permitted? This is a deeply complex question, answered differently by different societies, likely to vary as a function of the weight given to individual rights, prevention of harms, societal interests and welfare, and religious traditions. Chief among the concerns of those who argue against it is that what begins as a legal option may become an expectation; those who support it may view it as a right, a right that includes the liberty to sacrifice oneself for the benefit of others one cares about.

Should Altruistic Suicide Be Admired?

Permitting altruistic suicide is one thing; socially condoning it and admiring it is another. For example, Szmul Ziegelbojm, a member of the Polish government in exile in London, killed himself in May 1943 to protest the Allies' indifference to the Holocaust. Perhaps, he said in his suicide note, his death would arouse from lethargy those world leaders who would have to act if the handful of Polish Jews still remaining in the Warsaw Ghetto were to be saved from certain destruction. Ziegelbojm has been widely admired for both his courage and his altruism.

In the highly controversial but provocative view of the English poet and cleric John Donne, even Jesus Christ was a suicide. Donne argues that Jesus allowed himself to be crucified when he could have avoided it; he willingly emitted his last breath for the glory of God. However, Donne argues, Jesus was one of the only licit suicides, as suicide is ethically and religiously acceptable only when done for the glory of God. In Christian theology, no occasion of self-sacrifice is more admired than that of Christ; the question Donne raises for later scrutiny is whether it could be counted as (altruistic) suicide.

Social or legal permission for and admiration of altruistic suicide might be said to have coercive potential as well. Famously, Mary Rose Barrington asked, what if it were considered heedless self-arrogance to live on? And John Hardwig, stirring considerable controversy, insisted that one *ought* to end one's life if continuing it in the kinds of illnesses that could mean substantial burdens for one's family or significant others, an argument that would certainly apply to prolonged deaths by

cancer, organ failure, or advanced frailty and dementia, as the vast majority of deaths in the developed world now are. The question here is whether widespread societal admiration of such "suicide," called by some alternative term free of negative connotations, would come to be expected—the normal, essentially required course of action for anyone in such circumstances. This would of course return to the initial conceptual questions about suicide in general: not just what counts as suicide and whether suicide can be altruistic but whether altruistic suicide, which becomes normal and expected, remains altruistic and indeed whether it would have anything ethically in common with what now counts as suicide. Suicide is currently understood in contemporary medicine as largely nonvoluntary and self-referential, the product of depression or mental illness, something frequently stigmatized and always to be prevented. Widespread acceptance or admiration of altruistic suicide in a range of familiar end-of-life contexts would thoroughly challenge these assumptions. The phenomenon of altruistic suicide is already familiar in contexts such as social protest, jihadic suicide, and self-sacrifice in defense and military situations, but the issue of altruistic suicide as the societies of the developed world gray and age is likely to loom much, much larger as among the most challenging of moral issues at hand.

Margaret Pabst Battin

See also Causes of Death, Contemporary; Kamikaze Pilots; Suicide; Suicide, Cross-Cultural Perspectives; Symbolic Immortality

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Alzheimer's Disease

Alzheimer's disease (AD) is the leading cause of dementia in seniors. Although the condition also occurs in persons under age 65 (known as early-onset AD), this is extremely rare (approximately 2% of all cases) and involves a drastically accelerated version of the more typical disease course. Individuals with late-onset, or typical, AD can survive for 20 years with the condition, whereas those with early onset live only 3 to 5 years after diagnosis on average. Estimates purport that by 2050 the number of AD cases in developed countries will exceed 36.7 million. Currently, AD is estimated to impact 4 million Americans, or 8% of the U.S. population over age 65, with projections reaching 12 million by 2050.

Historical Background

In 1906, German psychiatrist Alois Alzheimer described the first case of what became known as Alzheimer's disease. Auguste D., a 51-year-old German housewife, presented at an asylum in Frankfurt with jealousy, paranoia, difficulty remembering, and nervous pacing and died after 4 years of progressive decline. Upon autopsy, her brain revealed innumerable concentrations of tiny clusters and dead neurons in the cerebral cortex; these amyloid, or neuritic, plaques and neurofibrillary tangles are now considered hallmarks of the disease. Dr. Alzheimer's second case, Johann F., a 56-year-old man who was forgetful, could not find his way, and was unable to perform

simple tasks was observed from 1907 to 1910. He died within 3 years of presenting symptoms, and countless amyloid plaques were found postmortem. Unlike Auguste D., however, neurofibrillary tangles were not detected.

With the advent of medical dominance in the 20th century, the question of whether or not old age, and thus senility, could be cured became a subject of intense debate. Therefore, Dr. Alzheimer described the cases of Auguste D. and Johann F. amid an existing controversy about the relationship between aging and senility. Because dementia was at the time considered a psychosis rather than an anatomical disorder, these cases were seminal in establishing a biological basis for insanity. In 1910, the eponym *Alzheimer's disease* was first used by Emil Kraepelin, a founder of modern psychiatry, in the eighth edition of his *Handbook of Psychiatry*. This assignment was based on the knowledge of only four documented cases despite the different neuropathology observed and the reticence of Dr. Alzheimer, who felt his cases demonstrated accelerated versions of the condition called "presenile dementia" rather than the discovery of a novel state.

Historians have suggested that Kraepelin may have rushed the definition of AD as a separate disease category unrelated to age to promote his own interests in discovering physical lesions. Accordingly, the ability to distinguish between normal and pathological brains was an important component in the establishment of AD. The term *Alzheimer's disease*, then, originally referred to dementia in patients with presenile onset of symptoms, whereas *senile dementia* was used when symptoms began after 65 years of age and was considered a natural part of aging despite the fact that clinically and pathologically the two conditions were strikingly similar.

Because AD can only be definitively diagnosed upon autopsy, from 1906 until the late 1970s its diagnosis was largely rendered postmortem. During this period, AD remained an extremely rare condition affecting only younger people. As early as 1933, however, the neurofibrillary tangles associated with AD were discovered in the majority of normal senile brains. Allegedly, most seniors experienced a degree of forgetfulness without it necessarily interfering with their daily living.

By the mid-20th century, however, senescence and senility were a unified construct, and an interpretation of senile dementia as pathological quickly overshadowed previous meanings. In 1968, a study reported that the same lesions observed in the brains of Auguste D. and Johann F. also are noted in 62% of autopsies. Throughout the 1970s and early 1980s, most scientists agreed that the distinction based on age of onset alone was arbitrary.

Over the next decade, leading biomedical researchers struggled to dispel the notion that AD was a rare condition. Each year throughout the 1990s, AD was either the fourth or the fifth leading cause of death in the United States. Through the application of the label AD to those over 65 years of age, a previously natural part of aging (senility) was thereby redefined as a national health problem. The scientific basis for unifying the terms *Alzheimer's disease* and *senility*, however, has been met with resistance given the different rates of decline, neuropathologic changes, and actual symptoms, and many argue that motivations to merge these two terms were political. Currently, it is not known whether early-onset and late-onset AD are the same entity, are entirely separate diseases, or exist on a continuum of the aging process, leading some to advocate a "spectrum approach" to dementia.

In concert with the National Institutes of Health, biomedical researchers and families afflicted by dementia banned together in search of accurate diagnoses, treatment options, resources for caregivers, and ultimately a cure. In 1980, the Alzheimer's Disease and Related Disorders Association (ADRDA) was formed. In October 1980, a letter to the newspaper column "Dear Abby" sought advice on caring for a husband with probable AD; the letter writer was referred to the ADRDA, which made the association visible to the public. The following year, Hollywood actress Rita Hayworth was reported to have the disease. Together, these factors brought the scientific studies highlighting the prevalence of AD to the attention of media and lay audiences. Consequently, AD emerged as an illness category and policy issue in the 1980s, more than 70 years after the first case had been documented.

Contemporary Context

Researchers and affected families have been at the forefront of shaping policy and research responses to AD since the 1980s, when the disease model of

dementia gained prominence in Western culture. Awareness of AD in the United States has largely been driven by characterizations of the burdens on families and society. Designations such as the unraveling of self and a slow death of the mind demonize the disease to focus public attention and political support to address the problem. In the United States, advocacy concentrates on increasing funding for biomedical research with the hope of finding effective treatments, and preferably a cure, for this disease. These efforts have predominantly been by proxy, with advocacy coming not from individuals with AD but rather from invested others.

Despite numerous autobiographies depicting the experiences of individuals living with the condition, subjective experiences have historically been marginalized or depicted third-person. Assumptions that it was impossible to ascertain the views of people with AD caused few attempts to be made and inappropriate questions to be asked, rather than exploring what was preserved or what were the (nonbiological) causes of the losses. Contemporary efforts to enhance communication and involvement, however, have demonstrated the enduring ability of forgetful people to meaningfully interact despite the stigma resulting from their inability to navigate the social world in a manner deemed normatively acceptable by others.

The initial exclusion of people with AD from discourse concerning their disease stemmed from the social disenfranchisement of people with forgetfulness that has arisen from at least three sources: (1) *in social arenas,* from the difficulties family members have accepting and understanding the changes in their loved ones; (2) *in political arenas,* by the demonization of the disease as a result of advocacy efforts aimed at increasing awareness of, and research funding for, the condition; and (3) *in scientific arenas,* by its objectification wherein biological and behavioral features of AD are reduced to their component parts in an effort to unlock its complex mysteries. These social forces highlight the role others play in ascribing the status of personhood. Bioethicists have long warned that such marginalization threatens to throw the most deeply forgetful members of society into a social wastebasket.

The loss of self associated with AD has been a dominant trope in America, reflecting a postmodern disorientation and skepticism regarding time-honored conceptions of the coherence and rationality of time, space, and selfhood. Some argue that through deep philosophical roots in modern science, AD and its symptoms came to represent an erasure of selfhood. Since being positioned as a member of a socially undesirable group can cause stigmatization, the resultant focus has become the disease and its manifestations rather than interactional or experiential aspects of *living with* AD.

Noteworthy recent exceptions include narrative accounts of the lived experience of people with AD that question the usage of the word *dementia* and call for a reframing of AD as an obstacle rather than an end; that depict stories of living positively with dementia; and that demand affected individuals be included as full participants in their adventure with AD. These works reconstruct AD by portraying accounts of diagnosed individuals living with what they call a manageable disability. These perspectives strongly challenge the notion that diagnosed individuals become a hollow shell by positioning people with dementia as situated embodied agents; selfhood is not defined by consciousness of thought but rather is a corporeal dimension of human existence. Therefore, dementia is an embodied breakdown, with the most severely impaired living in a world that simply does not appear meaningfully structured. The preservation of human dignity in the face of forgetfulness is critical, because characterizations of AD that serve political or scientific ends cannot sufficiently represent phenomenological aspects of the disease.

Diagnostic advances currently allow for the labeling of AD in the earliest stages and even the potentially preclinical phase called mild cognitive impairment (MCI). The diagnosis of MCI is highly contested due to controversies over the (f)utility of doing so based on a lack of efficacious treatment options and consensus on conversion rates to AD. Studies report conversion rates as small as 9.6% over 22 years and as large as 100% in 4.5 years. Research suggests that MCI cases may be just as likely to convert back to normal as to AD, with as many as 40% reverting to normal. This lack of consensus has led some neurologists and bioethicists to question the legitimacy of the preclinical label itself. Some argue that nosological expansions based on neuroimaging and genetics have made diagnosis even more ambiguous, as the uncertainty remaining, even after postmortem examination, calls its empirical reality into question.

The Future of Memory Loss

One consequence of earlier diagnosis is that we are moving into a period when people with the disease are being incorporated into the advocacy efforts that are part and parcel of AD culture. Although this may not signal the end of advocacy by proxy, it should herald a public face for AD. This may strengthen the potential for reorganizing the social typifications in ways compatible with more compassionate care models. Accentuating the sociomoral necessity to care for people with dementia in ways that recognize and preserve their dignity as human beings could also temper the demonization of the disease.

The contemporary conflation of personhood and sentience is arguably a socially constructed phenomenon within Western thinking, or an artifact of modernity. Related to our societal fears, obsessions, and/or denial of death more broadly, AD—and the social death it represents—is uniquely positioned as the most dreaded of diseases by which those afflicted become a mere fraction of their pre-AD selves. AD conjures repugnant images and engages political-economic debates salient to end-of-life issues, namely the gray zone of persistent vegetative state. Rhetoric of "the never ending funeral" suggests that AD is positioned as the worst of deaths, that is, a *living death*.

The combination of this discourse and the trend toward earlier and earlier diagnoses has potentially devastating ramifications not only personally and within families but also for societies within a world that is rapidly aging. Age remains the only known risk factor for late-onset AD. Allegedly, over half of the population that lives to be 80 will develop AD. In such a context, medical innovations simultaneously expand the medical gaze and hasten the start of the stigmatization associated with processes of social death. Earlier diagnoses extend and arguably intensify the personal and interactional tensions that all too often accompany memory loss. The potential impact of diagnosing someone with an unknown, untreatable condition has yet to be studied; subsequently, social scientists, medical practitioners, and bioethicists alike caution against too readily diagnosing the earliest "stages" of memory loss. The fact that AD can only be "definitely" diagnosed postmortem, if at all, renders this nosological expansion particularly salient in modern Western societies, especially regarding the ontology of human life (and death).

Renée L. Beard

See also Aging, the Elderly, and Death; Ambiguous Loss and Unresolved Grief; Caregiving; Life Cycle and Death

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Ambiguous Loss and Unresolved Grief

Rarely in human relationships are people totally absent or present. When loved ones disappear without finality of death, symptoms of unresolved grief appear. The cause, however, emanates from an external context of ambiguity that lies beyond the symptom bearer's control. Since the 1970s, this phenomenon has been called ambiguous loss. Unlike the clearer loss of death, ambiguous loss has no official validation of loss and thus fewer supports and rituals to help people begin grieving and coping. Without evidence of death, the incongruence between absence and presence is so distressing it can traumatize and immobilize individuals and families for years.

Types of Ambiguous Loss

There are many kinds of ambiguous losses, but these tend to fall within two types, one physical and the other psychological. In both types, however, a loved one's absence or presence, or status as dead or alive, remains unclear. Both types can occur at the same time.

Type 1 ambiguous loss occurs when a family member is gone but not gone for certain. Such people are physically absent but kept psychologically present because they could return. Catastrophic examples are people who have disappeared, been kidnapped, or are lost without a trace at sea or in wartime. More common examples of the physically missing are those due to divorce, adoption, incarceration, military deployment, and immigration. This first type of ambiguous loss is also called "leaving without good-bye." People are deprived of physical access to someone they care about, so they suffer a double loss: the loss of that missing person's physical presence plus the loss of volition in being able to say farewell. For example, in the case of people gone missing in wartime, children kidnapped, or infants given up for adoption, the physical transformation that marks death is a privilege denied. Without official verification or a body to bury, such families may never be assured of death, so they must live with the pain of no closure.

Type 2 ambiguous loss occurs when a loved one is physically present but psychologically absent. That is, they are here, but not here. The absence of such a loved one may be due to addiction, obsessions, or extreme preoccupation with work. Catastrophic examples result from dementias, brain injury, autism, and chronic mental illnesses. More common examples result from depression and, pertinent to this discussion, the melancholia of unresolved grief. This type of ambiguous loss is also called a "good-bye without leaving."

Brief History of Research and Theory Development

Grounded in stress theory, which focuses on the management of relationship stressors (in this case, ambiguity), the research on ambiguous loss began in the 1970s with families of soldiers missing in action in Vietnam and Southeast Asia. Since then, research has continued with families where there is dementia, military deployment, autism, traumatic brain injury, and family estrangement due to sexual orientation. Ambiguous loss theory has been applied to guide family and community-based interventions to cope with losses due to Alzheimer's disease, the missing after the terrorist acts of September 11, 2001, the kidnapped in Kosovo, the swept away in South Asia after the tsunami, and the displaced after Hurricane Katrina, among others. Whether loved ones are lost in body or mind, their families are likely to experience frozen grief—a sorrow that never ends because the mystery never ends. The therapeutic goal therefore is not closure but rather an increased tolerance for ambiguity. This is not an easy task in a culture that values mastery and certainty.

Ambiguous Loss as a Cause of Unresolved Grief

The idea of insolvability so inherent in ambiguous loss blocks the resolution of grief for several reasons. First, the ambiguity confuses people. Family members with loved ones lost, but not clearly dead or gone, do not respond completely to traditional grief and trauma therapies. Second, the ambiguity makes people feel helpless. In a culture that values answers, an unresolved loss is viewed with impatience and often blame. This further

isolates sufferers, eroding their resiliency and healing. Third, people with ambiguous losses are denied the symbolic rituals and supports that exist when there is a verified death in the family. They are uncertain about what to do. They understandably resist the grief process and feel guilty if they begin. Having no rituals and traditions to grieve with partial loss, many erase the ambiguity arbitrarily—by acting as if the absent person is clearly dead—or as if nothing has changed and that he or she will return as before. Fourth, the ambiguity freezes relationships in limbo. For example, young children presently at home are ignored as parents are obsessed with finding a missing child or being with a terminally ill spouse at the hospital. Fifth, friends, relatives, coworkers, and professionals often become impatient with people experiencing ambiguous loss and may equate the unresolved grief with personal weakness. Blaming the victim and withdrawing will only lessen the resiliency people need to live with the ambiguity.

Finally, because the ambiguity complicates both loss and its resolution, the idea of closure is counterproductive. In normal grieving, according to Sigmund Freud's perspective of mourning and melancholia, the goal of recovery is to relinquish one's ties to the loved object and eventually invest in a new relationship. This is the difficult work of mourning, but it is a process that is meant to end. From this perspective, emotionally healthy people are expected to resolve a loss and move on to new relationships—and do so relatively quickly. While some therapists now encourage living with grief, even from death, closure is assuredly unrealistic when losses are unclear. Once the goal of closure is let go of, individuals can more easily see complicated grief as a normal reaction to abnormal loss—an uncanny disappearance that continues relentlessly without answers. Unlike with death, ambiguous loss does not allow the detachment that is necessary for closure, or even resolution. Another approach is needed.

Increasing Tolerance for Ambiguity

The stress and anxiety people experience with such irresolvable loss is externalized and named: ambiguous loss. Externalizing and labeling the problem allow people to let go of self-blame and begin the coping and grieving processes. Knowing that even the strongest and healthiest people are overcome by ambiguous loss, people more willingly participate in individual therapy or family groups that help them move forward in their lives despite the ambiguity. Relieved that closure is no longer a goal, they more willingly think about what part of their loved one is irretrievably lost and needs grieving versus what part of that person is still present to be enjoyed and celebrated.

With ambiguous loss, the only opportunity for change and moving forward is to learn to hold two opposing ideas in perspective at the same time: "He is here, but he is also gone. She is present, but she is also absent. He is in all probability dead, but maybe not." "Both/and" thinking serves to strengthen people's resiliency in the face of unanswered questions. Said another way, it is useful for family members to be able to accept the paradox of absence and presence. By embracing the contradiction, people are better able to manage the stress of ambiguity and live well despite the lack of closure. Six guidelines for increasing tolerance for ambiguous loss are summarized here.

Finding Meaning

At some point, the goal is to find some positive meaning in the loss and ambiguity. This is done by reconstructing the narrative of what happened into a new story that hopefully eases self-blame, guilt, and the desire for retribution or violence. Positive meaning is best found through voluntary listening and telling stories of pain—and strength—in the company of others who have experienced similar loss.

Tempering Mastery

Research suggests that the more people are accustomed to mastering problems and controlling their lives, the more depressed they become with ambiguous loss. Highly mastery-oriented people have less tolerance for ambiguity and thus feel more helpless when faced with unresolved problems. Tempering mastery means increasing one's tolerance for ambiguity.

Reconstructing Identity

It is confusing to know who we are in the context of a missing family member. People begin to

question their traditional role set if the only role left is to take care of a mate who no longer knows his or her spouse. Gradually, they must reconstruct who they are in relation to the missing loved one. For example, the wife of an Alzheimer's patient said she no longer saw herself as a wife but as a widow-waiting-to-happen.

Normalizing Ambivalence

The ambivalence experienced with ambiguous loss is "sociological ambivalence," meaning it is caused by an external social force, not psychological weakness. While ambiguity understandably feeds ambivalence, conflicted emotions such as love/hate and anger/joy must be managed. Talking with others professionally or in groups helps to bring negative feelings into one's consciousness. Once acknowledged, discussions about how to prevent harm can follow. Wishing loved ones dead when they are missing or in pain is not unusual or wrong. With ambiguous loss, ambivalence is inevitable, so it is essential to talk about this topic with others.

Revising Attachment

The stress related to not knowing whether a person we love is here or gone illustrates an intersection of cognitive and psychodynamic theories. In an environment of ambiguity, confusing attachments and the lack of meaning are linked to blocked decision making and coping processes. In such contexts of doubt, relationships are conflicted. Revising one's attachment to someone who is ambiguously lost requires a new view of absence and presence and a tolerance for paradox and no closure.

Discovering Hope

The father of a boy lost in the mountains tells reporters that his search will not end until he finds him. Understandably, he hangs on to hope that his son is still alive somewhere and will be found. Later, if the boy is not found alive, the father may discover new hope that the boy's remains will be found so that he can bury them. An alternate method is to symbolically honor the child through creating a form of remembrance within family and community. What one hopes for must change as time passes, but this happens best in narrative with others. When loved ones are kidnapped, swept away, buried alive, or vanish in mind or body, family members continue to hope. Rather than seeking closure, the goal is to imagine and discover new hope.

In conclusion, while the unnatural mystery of ambiguous loss can traumatize, most people eventually move forward with their lives. They accomplish this by holding two opposing ideas in their mind at the same time: the person I love is here, but not here; gone, but not gone. Grasping the contradictions in absence and presence provides the resiliency needed to move forward with life, even after experiencing losses that defy resolution. Remembering that the pathology lies outside the individual helps lower blame and stress.

Pauline Boss

See also Aging, the Elderly, and Death; Alzheimer's Disease; Bereavement, Grief, and Mourning; Chronic Sorrow; Grief, Types of; Grief and Bereavement Counseling; Hospice, Contemporary; Prolonged Grief Disorder

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American Indian Beliefs and Traditions

American Indian beliefs and traditions include reverence and respect for life. Death is not all that different than life, for everything is sacred. Every part of the dirt, rocks, trees, of all things, is sacred.

The ashes of the dead are resting in sacred ground. Rather than disconnecting with the dead, American Indians continue to have a relationship with the dead. Rather than fearing death, it is a part of the life cycle to be accepted. The deceased continues to be loved and continues to love, care for, and protect the living.

All life is important. The plants and animals that gave up life in providing sustenance on a daily basis are thanked, as is the soil that nourishes the plants and the animals. Mother Earth is thanked for providing sustenance to the living. Everyone, including the least among the community, is thanked for contributing to the people's survival. This is the credo of American Indian beliefs and traditions as these pertain to the death and dying human experience. In the following sections historical and contemporary practices are examined.

Historical Development and Decline of Tradition

Native American burial and bereavement practices have been changed and forgotten over many centuries. The infusion of European religions, the lack of a written history of religious and spiritual practices, and the decline and death of many Native American languages means that many practices and ceremonies have been lost forever. Although some tribal groups cease practicing traditional ways, for all cultural groups death remains a village affair. People wash and prepare the body. Family and friends mourn the loss; some wear mourning clothes. All engage in mourning practices as the deceased is assisted on his or her journey by song, laments, eulogies, gossip, laughter, joking, appeals to spirits, appeals to God, dancing, prayer, and ritual. Some cremate, some bury the deceased.

Impact of Christianity

Like many clans, the Flathead Indians combine Christian and quite often Catholic traditions with their own traditional ways. Some Christian clergy act with respect and try to preserve traditional ways. Many funeral directors also respect and preserve traditional ways. Others attempt to destroy the traditional American Indian beliefs and practices.

Also known as the Salish, Bitterroot Salish, and as the Pend d'Oreille or Kalispel, the Flathead and other Plains Indian groups assimilated many Christian practices. The sign of the cross, "In the name of the Father, the Son, and the Holy Spirit," for example, is translated "L'squest's Le-eu u Sku-se u Sant Spah-pah-paht. Ko-mee e-tse-hyl." Flathead funerals include wakes and feast days are celebrated. Believing that death comes to all, young, old, rich, or poor, the Flathead are always ready for the inevitability of death. Each morning, one gives thanks to God for the day, for life, and for assistance in surviving the day. Prior to sleep, one gives thanks to God for the day and to awaken another day. Death is not feared; rather, death is anticipated as a joyous event. For the Flathead the wake represents a spiritually uplifting experience for all. One greets the deceased and prays with the prayer leader and someone stays with the deceased throughout the 1- to 3-day wake.

Prayers are spoken while the grave is opened and closed, during the procession to the church, during the funeral, during the procession to the cemetery, and during memorial and feast days. Many years ago, feasts and memorial giveaways were planned for a year after the death; today, most plans are made for a memorial dinner and giveaways are scheduled for disbursement immediately after the burial. A contemporary issue is that everything is finished quickly, leaving little to enhance thoughts of the future. This provides the family little opportunity to grieve and to express sorrow. Those who receive keepsakes help take away the sorrow of the bereaved. Material things are not important, but the love that the items represent is essential. Deferring the feast day and memorial dinner allows the family to release their sorrow. But abandoning this practice by adopting Christianity and modern practitioners has served to erode traditional beliefs and traditions.

Burial and Bereavement Practices

Burial and bereavement practices vary among American Indian clans. The Ojibway Indians, for example, believe that it is important to feel good about self and to live life in a manner that reflects appreciation for all living things, to avoid harming or destroying life. Ceremonies begin with a tobacco prayer offering. The pipe's smoke carries the prayer to the creator.

The Ojibway bury their dead in their best clothes along with tools, tobacco, and food to take on the journey to the land of the souls. However, many burial mounds have been sold and developed into housing tracts, roads, and other intrusions. Many other burial sites have been looted, excavated by archaeologists, and bulldozed under building construction. To prevent further violations, the Wisconsin Ojibway have purchased many of these mounds.

The Iroquois Indians also bury objects with their dead. They fast for 10 days, and surviving spouses do not remarry for a year. Some groups blacken the face of the mourners and the dead person. After tattooing the body, the corpse is decorated with feathers and wrapped in furs and then buried either on a scaffold or below ground. The Iroquois believe that the soul does not leave until the Tenth Day Feast. At this feast, the possessions are given away and the favorite foods of the deceased are served to guests.

The Assiniboine Indians of the Great Plains place the corpse on scaffolds with the feet pointed to the west. After the scaffolds rot, the bones are collected and, except for the skull, buried. The skulls are used in a sacred village of the dead ceremony during which time friends and relatives speak to the dead and leave gifts.

The Hopi Indians are noted for having simple ceremonies in honor of the dead. Symbolizing a rain cloud, the face is covered with a mask; a woman is buried in her marriage gown, the man dressed in clothing appropriate to his clan status. The Hopi silently lower the body into the ground with prayer sticks, cover the grave, and leave food for the journey to the spirit world.

The Diné, or Navajo, Indians believe disease and death result from evil doing, witchcraft, spells, and dreams. One counters evil through ceremonies of blessing. Death represents the beginning journey to the next life. Grandparents receive respect from the children as they listen intently as elders speak of life and death and grief.

Throughout the life span, the Navajo passively accept death and the other traumas of life. In the wake of the death of a loved one, withdrawal is a common response to grief and loss. Women are more likely to cry openly. Men cry, but not publicly. Both are likely to have engaged in long periods of nonproductivity while experiencing a loss of interest in life and its pleasures. Although mothers and sisters continue to work, it may be months before the grandfather returns to his craft or sheepherding. Children, on the other hand, quickly return to their usual ways.

The Apache Indians employ strong interpersonal communications, humor, music, art, and social support to deal with illness, injury, and grief. The Apache believe that the spirit of the dead does not immediately depart for the underworld, and thus relatives who touch the body are likely to experience ghost sickness and may themselves require healing.

Apache are dressed in their best clothes, wrapped in a blanket, carried to the hills, and placed into a crevice or a shallow grave. Among the Western Apache, ashes and pollen are sprinkled in a circle around the grave, beginning at the southwest corner, to offer the soul a safe journey to heaven; in addition, water is left by the gravesite.

Crying and wailing occur during the Apache wake. Sometimes the body is left in the wickiup, which is pushed down upon the body. The Chiricahua Apache wives and children cut their hair short, cover their faces with mud and ashes, and dance to avoid ghosts from capturing them after the death of a warrior. Yuma Apache, the only Apache group to cremate their dead, also burn all of the deceased's possessions. In recent years, however, funerals and wakes have become a common practice.

The Apache mourn and wail, cut their hair short, and continue to mourn until their hair length is reestablished. Many Apache or Inde have incorporated nontraditional ways such as memorial dinners, Christian hymns and rituals, and the use of funeral directors.

Among Plains Indians, tribal attitudes and beliefs pertaining to dying and death are varied. The Lakota view the soul as having at least four distinct attributes: Ni un, Sicun, wann'gi, and Ton. Like the breath emitted from the body on a winter day, Ni un (life) leaves the body at the moment of death. But it is this aspect of the soul or spirit that is most feared because of the uncertainty of when the body is free of the spirit.

Sicun (spirit helper) is the second aspect. Like the Kachinas of the Hopi, the dead can assist the living. Like the Catholic concept of guardian angel or guardian spirit, the Plains tribes look to the

dead to help the living. As Catholics look to saints and deceased relatives to intercede for them, Plains tribes look to the Sicun.

The third aspect, wann'gi (spirit shadow), helps others; it can also be angry with the living. The shadow world and spirits are discussed by many tribes. Stories and tales of wandering ghosts or displaced spirits indicate these spirit shadows dare not be offended. Much of the secrecy they maintain surrounding burial and grieving practices is based upon this concept.

The final aspect is Ton, or power that makes something. One should listen to and respect the earth. Because they have power and can teach, the living rocks, earth, plants, feathers, and tobacco, for example, are used to make medicine and in rituals to help the living.

Grieving ceremonies are important to the Plains tribes because it is believed that the living and the dead affect each other. Each life has a purpose, a reason for being; each death takes away a critical, functional component. As the fox, coyote, squirrel, or rabbit has a purpose, so do each of us. If the coyote becomes extinct, its message is lost. Among humans, violent death as well as death attributed to suicide and accidents is cause for mourning. We will all be the less for not learning their message. Each death must be mourned, but those who leave the world go on a spirit trail. When death occurs, the deceased sees all of his or her relatives and waits for his or her descendants to join them.

Cremation

Cremation was the dominant form of body disposal for Yuman-speaking tribes—including the Hualapai (Walapai), Yavapai, Havasupai, Mohave, Cocopah, and Maricopa—the Kumeyaay (also called the Diegueño), and others. The Yuma of the Lower Colorado River and the Shoshone tribes of the Great Basin also employed cremation, as did some northwestern Central and South American tribes. But mission life generally destroyed traditional aspects of cultural life for most tribes. Crowded into small towns, these tribes experienced dramatic changes to their culture, eventually incorporating and adopting new crafts and methods of farming, new foods, new forms of housing, and different religions.

Catholic missionaries encouraged tribes to practice earth burial. With great difficulty, the missionaries convinced the Northwest Coast Indians to adopt the white man's cemetery even though they viewed earth burial with horror. Indians who had less contact with the Spanish and their missionaries were able to keep more of their traditions and way of life intact.

The Mohave Indians resisted the Mission movement. When death occurs among the Mohave, the corpse is quickly laid on a funeral pyre that will be prepared prior to death if death is anticipated, after which cremation follows as soon as possible. After the fire is lit, mourners wail, throw goods, and throw even their own clothes onto the fire. After the fire is complete, the mourners push the ashes and remaining debris into the trench or pit and cover it with sand. Generally, all of the dead person's property, clothes, goods, and even food is burned, and all evidence of the individual ever having lived is destroyed.

Ceremonies continue for 4 days to include abstinence from eating meat, fish, or salt and even from drinking water. Purification rituals are part of the activities of the mourners. The Mohave believe that the soul remains 4 days before departing. Those who prepare the body or touch the dead person or give speeches typically are part of these purification activities. This would involve cutting hair, bathing, and participating in smoke ceremonies and secret rituals. Although most of the old ways, foods, housing, dress, plants, and ways of making a living have disappeared, clan and cremation have remained among those who live in the old way. Although their religion is mostly extinct, the Mohave have not assimilated the Christian beliefs and traditions as did most tribes.

Less affected by the Catholic mission system, the Quechan, or Yuma, are also known for using cremation. The Yuma also were less impacted by the mission system. Near neighbors of the Mohave, their cremation practices are similar. The Yuma built funeral pyres that were house-high masses of logs upon which was placed the dead person. Mourners wail, cry, dance, sing, tear their clothes and throw them into the flames, scratch their faces, throw offerings or even money into the fire, request spirits to take this dead person and those who have died before, burn images of the dead person, and burn their personal items. They mourn for 4 days.

The Shoshone habitat varied, ranging from Death Valley to the Yellowstone Park area. The West Coast Shoshonean include Mono, Serrano, Gabrieleno, Luiseno, and Cahuilla. The Southern California Cahuilla also practiced cremation and burning the houses of the dead; they mourned, and they held mourning ceremonies.

Ancient tribes also practiced cremation. The Hopewell of the Middle Woodlands, perhaps more studied than most Woodland cultures, practiced both burial and cremation.

In conclusion, it is clear that tribal groups provided the dead with ceremonies and dignified disposal. There is much evidence that North American tribes employed all known methods of disposal of the dead, including burial (both ground and air), cremation, and mummification. It is also probable that the cause of death, where the death occurred, the age of the deceased, the sex of the deceased, and the social status of the deceased impacted the mortuary and burial practices of the tribe. However, sufficient information about how such factors influenced burial practices is not conclusive. It is likely that climate, availability of materials to dispose of the body, and religious beliefs were major determinants in how bodies of the dead were disposed.

Native Americans provide social support through the tribe or clan of the individual in the dying and burial process. That same social support system sustains the bereaved after the disposal of the dead. The grief process includes the ceremony of the funeral, the cremation, and the bereavement ceremonies. Extreme emotions are usually managed by these ceremonies. The spiritual nature of the living and the dead permeate the entire process.

No analysis of mortuary and burial practices could provide a complete picture of the attitudes and values of a particular people toward dying and death. One would need to observe hundreds of funerals to uncover subtle practices that might distinguish one funeral from another, even in the same culture. Each funeral will differ because of differences in the age, sex, social position, amount of disposable income, or other factors that characterize either the deceased or the survivors who provide the funeral. Other factors would also include the cause of death, the time of year in which the death occurred, or the personality of the person who died. The attitudes of the survivors or the deceased could impact the type of funeral practices that emerge as well.

Gerry R. Cox

See also Ancestor Veneration, Japanese; Body Disposition; Cremation; Spirituality; Wakes and Visitation

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Ancestor Veneration, Japanese

In attempting to make sense of death and human experience, many societies have drawn on a discourse that emphasizes the sacred nature of family ties. Such a discourse encompasses beliefs, norms, understandings, and practices that foster continuing relationships between the living and the dead, in which the dead retain an active social presence in the lives of the living. These are explored by focusing on *sosen sūhai,* the Japanese form of ancestor veneration, as highly illustrative of the defining nature of discourses of death for the way people make sense of and structure their lives. This entry examines the way Japanese people

relate to their ancestors through beliefs about life and death, family dynamics, political imperatives, and personal expression.

Beliefs About Life and Death

Ancestral ties are deeply embedded in the Japanese psyche to encompass a familial devotion that is spiritual, even mystical in character. Indeed, sosen sūhai represents an indigenous faith that has remained separate from more formal religious traditions, though having absorbed elements of these, particularly Buddhism. As such, the ancestors or *senzo* represent the main source of religious experience for Japanese people, who tend to consider themselves a secular nation. However, belief in an afterlife where one will eventually join the ancestors is widespread.

The mystical nature of family ties has its roots in early indigenous beliefs and customs that predate the influence of Buddhism, from which they have since been distinguished by the name of Shinto. These emphasize the presence and power of the natural world through the concept of kami, or spirits of nature on which the living depend for their existence. The sense of being surrounded and supported by spirits reflects an agrarian lifestyle based on continuity and harmony between the worlds of nature and culture through close-knit, enduring kinship groups whose dead members become kami. As such, they are objects of veneration.

With no distinct line between the living and the dead, or human and divine, the dead remain available to the living for support and protection, while continuing to depend on them for their well-being, requiring earthly nourishment and devotion from surviving kin. Without sufficient care and attention, the dead may use their supernatural powers to cause trouble for the living. Indeed the dead are feared both for their polluting powers through the corpse as well as the potentially dangerous nature of the spirit. The well-being of the living thus depends on administering to their needs through rituals designed to placate, purify, and petition them.

Family Dynamics

The household, or *ie*, has been the main context for such beliefs and the rites that support them since the 16th century, to shape the moral foundation of Japanese society. Reflecting a discourse of continuity, perpetuity, and harmony, the ie came to represent a spiritual community in which both living and dead family members were essential for its existence and responsible for its welfare and continuity. Such values could take precedence over blood ties. Though ideally the perpetual existence of the ie is based on a system of unilateral succession that is patrilineal and primogenitural, in practice it is not synonymous with kinship. Outsiders may be adopted in if they prove more capable of ensuring the ie's continued harmonious existence. These values are reflected in the mutual affection that characterizes Japanese ancestral ties, encompassing gratitude on both sides, the living for the legacy their ancestors have left them, and the dead for the continuing prosperity of their line.

From at least the 8th century, Japanese families have engaged in sosen sūhai in a way that expresses family solidarity and mutual caring and support for both the spirits of the dead and their living relatives. Such mutuality includes the role of the living in ensuring that the spirit of the newly departed, the *shirei*, receives a safe and peaceful passage to the afterlife. Through a series of rituals, lasting 49 days, the shirei is divested of its polluting association with the corpse and attachment to the world of the living and set on the path to becoming an ancestor. This process is also designed to reassure the shirei of the family's continuing devotion and concern for its well-being. Otherwise it may become angry and resentful and cause harm to the living. Thus these rituals encompass a placatory dimension to ensure that potentially unsettled spirits become settled. Indeed, the concern of the living for the fate of the dead may extend to taking in those spirits who have no one to care for them, reflecting the group-oriented nature of Japanese culture in which the greatest fear is of social isolation. Such concern is reflected in *o bon*, the major summer festival, which welcomes the dead back into the community of the living, giving special place to those who have died since the last o bon.

Strictly speaking, therefore, recently deceased family members can be distinguished from the ancestors, though they will eventually gain ancestral status with the passage of time and appropriate rituals. Until then the dead form the focus of very personal relationships for as long as people are alive who remember them as individuals. These

are conducted at the *butsudan*, the domestic Buddha altar, where offerings of food, water, and flowers are regularly placed, incense and candles lit, and prayers said. Conceived as a mini-temple, the butsudan houses the *ihai* or wooden tablet representing the deceased person's spirit and bearing their posthumous Buddha name (*kaimyō*).

Eventually the remembered dead will fade from memory, lose their individuality, and merge with the family ancestral spirit (*tamashī*). In the meantime, through a process of ritual purification culminating in a final memorial service on the 33rd or 55th anniversary of death, they are rendered fully purified and benign. Thus, fully fledged ancestors tend to form a collective to whom ties with the living are no longer personal and vertical but rather collective and horizontal. In reality such a distinction is less clear as personal memories may be passed down the generations and the conceptualization of ancestors is changing to accommodate contemporary urban lifestyles and values.

Political Imperatives

The importance of ancestral ties to a culture based on close-knit, harmonious communities has been subject to political exploitation, early on forming part of the 6th- and 7th-century promotion of Buddhism. Then, more recently, the 17th century stamping out of Christianity by the Tokugawa government required all households to register at Buddhist temples. These then became the locus of ancestral rites with the Buddhist priest as the officiant. Prior to this ancestor veneration was a household-centered affair requiring no relationship with formal religion or the state. For the first time sosen sūhai took the form of a structured ceremony requiring temple and priests for its legitimation.

This political act resulted in a new popular form of Buddhism, which prior to this time was a religion of the upper and educated classes. Buddhism became central to sosen sūhai to which the institution accommodated itself and in so doing ensured its continued existence. This enabled the government to institutionalize devotion and loyalty to the emperor, via such rites, through the extension of people's sense of familial obligation. The ideology of *kokutai* was promoted as a mystical force residing in the Japanese people as a patriarchal nation in which all people are related to one another and to the emperor. The more horizontal dimension of sosen sūhai was thus reinforced.

Then in the Meiji period (1862–1912) such a binding of Buddhism with emperor worship via domestic ancestral rites was rekindled, with the addition of the *kukotu* ideology being disseminated through the education system. Until the end of World War II, children were brought up to believe that they were part of a long unbroken history of close-knit harmonious communities owing loyalty and obedience to their ancestors and ultimately the emperor. However, the Meiji government's attempt to establish Shinto as the national religion eventually failed as a result of the way sosen sūhai had by now, with almost 300 years of being tied to the state, become synonymous with Buddhism. Indeed, this link still remains even though it no longer serves political ends.

Personal Expression

Since World War II, Japan's increasing urbanization has had enormous impact on both the structure and ideology of the ie. Contemporary city-dwelling conjugal families owe no allegiance to their ancestors based on inheritance of property or long-term coresidence. An agrarian lifestyle, kinship ties, and a sense of the presence of the natural world are no longer the norm for many Japanese people. Yet, in spite of the waning household system, interaction between the living and the dead continues, suggesting that it is not dependent on institutional factors. Rather its persistence has to do with the importance of the more personal dimension. For sosen sūhai is not only about kinship solidarity but also about remembering particular individuals, something that is reflected in the increasing personalization of funerals. In the context of the nuclear family the emphasis has shifted from distant ancestors to more immediate kin. Indeed people's conception of ancestors has become more flexible to include family on both sides rather than only the patrilineal line.

Thus, ancestral ties continue to find expression through private rituals in domestic spaces that people continue to construct for them. For many this will still be the traditional butsudan, whereas for others it may be a smaller memorial space where photographs and other personal items are

kept. More compact, contemporary-style butsudan that can be easily accommodated in a small apartment are now available as *temotokayou* (home memorials), reflecting a shift in emphasis from veneration to memorialization. However, the quality of veneration remains in that family ties have come to represent a profound sense of emotional security and belonging for many Japanese people. The sense of gratitude and respect for what the ancestors have left behind has become linked to the sense of owing one's very existence to one's ancestors.

The forms these private rituals may take are highly varied to reflect the nature of the individual to whom they are directed, such as offering their favorite food and flowers and keeping them in touch with those family matters that are likely to be of particular interest to them. The sense of continuity between this world and the next still finds expression in people's concern to provide dead loved ones with those comforts that reflect their particular preferences in life. It finds expression in the continuing belief that the dead depend on the living for their well-being, sosen-sūhai encompassing *sosen-kuyō*, or praying ***for*** as well as ***to*** the ancestors. The sense of responsibility that Japanese people feel for the well-being of their dead informs the funerary and after-rites that assist the spirit's safe and peaceful passage to the afterlife, the emphasis on pollution having shifted to concern for deceased loved ones' individual needs and comfort. Thus for contemporary Japanese people sosen sūhai continues to reflect a social world in which the fate of both the living and the dead are profoundly interdependent.

Christine Valentine

See also Animism; Buddhist Beliefs and Traditions; Communicating With the Dead; Holidays of the Dead; Shinto Beliefs and Traditions

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Ancient Egyptian Beliefs and Traditions

The ancient Egyptians created a complex civilization that continues to be studied over 2,000 years after the death of the last pharaoh. An undercurrent of matters in ancient Egypt was their system of beliefs, at the center of which existed the struggle between order (*ma'at*) and chaos (*isfet*). When ma'at reigned, people were happy and prospered. When ma'at was not maintained, isfet occurred, the harvest was unsuccessful, the land was plunged into war, people suffered. Therefore, actions were taken to ensure the preservation of ma'at.

The ancient Egyptian culture was rich and complex. Numerous rituals were a part of their system of belief and were woven into aspects of life, ranging from the mundane tasks of everyday living to abstract concepts. The religion of ancient Egypt garnered respect and wielded influence years after the system of government practices by Egypt's pharaohs. The culture and religion continues to be studied thousands of years later and, in that way, ancient Egypt lives on.

Egypt's Cultural Complex

The ruler of ancient Egypt, the pharaoh, was viewed as the key component in the continual efforts needed to sustain ma'at. In addition to the ruling pharaoh's secular duties to make Egypt prosperous, the nation's monarch was also charged with keeping the numerous deities of

Egypt's religion satisfied so that they would, in turn, bless the nation with blessings ranging from prosperous harvests to military victories and guard against the forces of isfet.

During life, a pharaoh was viewed as the living embodiment of the falcon-headed god Horus; upon death, the ruler was believed to have joined Osiris, the god of the dead (the father of Horus). In later dynasties, the view of the people regarding the divinity of deceased pharaohs was heavily promoted; for example, monuments dedicated to Amenhotep I (r. ca. 1514–1493 B.C.E.) included prayers to gain the deceased pharaoh's blessings and assistance.

As the link between the gods and humans, certain rituals required and could be performed only by a pharaoh; the priests, who occupied the upper echelon of Egypt's social structure, located in the official temples located throughout the nation assisted the pharaoh's efforts to carry out the rites demanded by Egypt's religion and in the continuous attempts in maintaining ma'at.

The many stories that discuss Egypt's complex religion show the attempts of a civilization to explain natural phenomena (similar stories exist in many ancient as well as "traditional" religions), such as the movement of the sun (the god Ra and/or Re). Other gods and goddesses were dedicated to certain events, such as childbirth (the goddess Heket). Deities were also associated with abstract concepts, such as wisdom (the god Imhotep), or would be held as serving multiple roles. Egypt's gods and goddesses took different types of forms (including taking human forms, animals, and a combination of the two); some deities would be associated with a variety of appearances. The god Thoth could be shown as an ibis, a baboon, or a man with the head of an ibis. In addition to these different forms, Thoth was associated with various roles, such as knowledge, the Moon, and of scribes. Names were also critical to the power of a deity; prayers, rituals, and gifts could be made only to a god or goddess that had its own name. Some Egyptian deities, such as Re/Ra, also had secret names. This mystery was critical inasmuch as it served as a source of power.

Significant deities of Egypt's religious pantheon symbolized natural forces such as the Nile's annual inundation upon which the people were dependent. These included the god Hapy, whose appearance was that of a man wearing a headdress of aquatic plants or the events throughout a human's life span, such as birth, childbearing, and death.

Among the best-known Egyptian myths are those involving Osiris and Isis, who are portrayed, respectively, as a mummified man, at times with green, black, or white skin, wearing a crown, and holding a crook and flail and as a woman with a throne headdress; the traditions and rituals surrounding these two deities are mentioned in the writings of other civilizations, such as the Greek author Plutarch in his work *DeIside et Osiride*. Osiris was a part of the mythology that was revered at the ancient site of Heliopolis located at the southeastern delta section of the Nile and is referred to in the Old Testament (as On). Osiris and Isis were two of nine deities known as the *Ennead* (Greek for "group of nine") or by the Egyptian translation *pesedjet*. Born from the union of the goddess of the sky (Nut) and the god of the earth (Geb) were five children: Isis, Osiris, Seth, Nephthys, and Horus the Elder. As the oldest son, Osiris became the king of the earth and took his sister, Isis, as his queen consort. Seth, unhappily married to his other sister, Nephthys, was jealous of Osiris' kingship and took steps to gain the throne for his own.

As the myth goes, Seth invites his older brother to a feast supposedly to worship the gods. At the start of the feast, the attendees were presented with a macabre prize, a coffin-shaped chest, to whoever would be brave enough to test its size. While others tried, all the other party goers failed as Seth had arranged its construction to fit Osiris and no other. As part of the fun, Osiris entered the chest, Seth and his co-conspirators slammed down the lid and sealed the king inside the now very functional coffin and cast it into the Nile. Osiris' drowning introduced death to the world. Grieving over the loss of her husband, Isis undertook to find the body of Osiris and through her efforts, Isis was able to retrieve the body of her murdered husband and through her magical abilities was able to reanimate a child, Horus the Child (typically referred to simply as Horus). But Seth had heard of Isis' efforts, and while she was out with her son, Seth was able to mutilate the corpse of his elder brother, cutting the body into 14 pieces, which he then scattered throughout Egypt. Seth and his evil cohorts also physically damaged Horus, at one point gouging

out his eyes. His mother, Isis, used her magic to heal his wounds; symbols of Horus (including the "Eye of Horus" also known as *udjat* or *wadjet*) came to be held as protective amulets and aided in efforts of healing.

Dejected, Isis once again took up the quest to find all of Osiris' body parts and through her diligence she was able to find all, save one piece, Osiris' penis, which had been eaten by a fish in the Nile River. Some myths attribute the fertility-infused silt of the Nile that gets washed onto the banks of the river during the season of inundation to the infusion of Osiris' male member with Egypt's life source. Finding all but one part of his body, Osiris was bound together with strips of linen. Thus, he was held to be the first to be mummified. The myth of Osiris reflected the belief that in order to pass through to the afterlife, an intact body was needed; the mummification process described in the myth also provides a model for funerary practices and rituals. Additionally, the myth binds life with death (as well as the continuation of life after death) and fertility in humans as well as harvests.

Horus sought to avenge his father. Eventually he was able to defeat his evil uncle, Seth, and gain the throne; the son of Isis and Osiris was held as the god of the sky, kingship (as previous stated living pharaohs were believed to be the living embodiment of Horus), and authority.

Ma'at was held as the goal of Egyptian culture. The goddess Ma'at, represented as a woman wearing a headdress of a single typically white feather, was the guardian of order, justice, and truth. When depicted in Egyptian art, a feather symbolized the concepts protected by Ma'at.

Anubis was another god of importance in the Egyptian religion. The god of embalming and cemeteries, Anubis was commonly pictured as a man with the head of a jackal. People would offer prayers to him to help the deceased. Priests performing burial rituals and ceremonies would oftentimes don jackal masks in order to portray Anubis.

The goddess Hathor was portrayed as a cow or a woman with the ears of a cow. She was held as the goddess of various things and concepts such as love, sexuality, fertility, motherhood, dancing, music, and alcohol. Hathor was also viewed as the divine mother of the pharaoh and is portrayed in some Egyptian works as the consort of Horus. Monuments in her honor feature prayers to Hathor for fertility and safety in childhood.

Re was the Sun god and held to be a creator. As the sun is a critical component to agriculture, Re was held as being a powerful and important deity within Egyptian religion. Various objects, such as portrayals of sun disks and obelisks, came to symbolize Re. At times he was pictured as having a man's body and the head of either a ram or a hawk wearing a headdress featuring a sun disc. During the day, Re was believed to travel by boat across the sky, while at night he was thought to pass through the Underworld. Another version of the passage of Re stated that each night he was swallowed by the sky goddess Nut and passed through her body to be reborn in the morning. At various times throughout Egyptian history, Re was melded with other deities, such as Horus (becoming Re-Horakhty, "Horus of the Two Horizons") as well as Amun, who was at times the head god of the official state religion (to become Amun-Re).

During one portion of the Eighteenth Dynasty (ca. 1539–1292 B.C.E.) of ancient Egypt, a new belief system was introduced as the state religion. Introduced by Akhenaten (r. 1353–1336) the sole deity of this new religion was the Aten, the manifestation of the sun itself. While the Aten was not a new concept, it had not previously been promoted as the only god. The Aten was depicted as the sun disc and typically featured rays that ended in hands. The Aten was thought to give, through the rays of the sun, life to members of the royal family, and only they could directly worship the sun. Others practiced the religion of the Aten by worshipping at shrines featuring the royal family in the presence of the Aten (as a sun disc).

The concept of monotheism was in extreme contrast to the traditional Egyptian religion and did not connect with the past. The priests who traditionally held great power and influence within the nation were threatened and neither they nor the Egyptian public were fans of the religion of the Aten. Shortly after his death, Akhenaten was declared a heretic and the traditional polytheistic Egyptian religion was restored.

Art

Art in ancient Egypt served not only aesthetic purposes but also was held as satisfying other aspects

of life. Pharaohs used idealized portrayals of themselves to propagate the concept of the king being a perfect quasi-deity. Representations of gods and goddesses were believed to actually become that deity. Images, such as art and writing, were critical components in carrying out certain rituals and activities; words, written and spoken, were held to have transformative power. Moreover, objects that could be considered pieces of art, like protective amulets (like the "Eye of Horus" described earlier), were common features in an Egyptian's everyday life. Due to space limitations, only art serving a ritual or religious purpose is discussed here.

Duality was a common theme throughout Egyptian culture: life and death, drought and inundation, arid desert and lush oasis. A central belief within the Egyptian religion was the struggle between order (*ma'at*) and chaos (*isfet*). The primary goal of religious rituals was the maintenance of ma'at. Additionally, in the Egyptian mythology, the world at its creation was perfect and no alteration was needed. As such, Egyptians strove for preservation, not change; rituals helped tradition endure and allowed people to feel a connection to the past.

The pharaoh was at the center of executing the rituals and actions required by Egyptian religion. In addition to the spiritual duties, the pharaoh was also the head of the nation's secular realm. To help the ruler, priests helped to carry out the multitude of religious rituals, rites, and tasks and would act as the pharaoh's agents. The priests occupied a place in the upper ranks of Egypt's society and could wield extreme influence.

As with the case of Akhenaten and his attempts to reinvent the country's religious beliefs, the priests of the traditional belief system used their power to squash the monotheist theology of the Aten and in doing so tried to wipe out the monarch, declared as a heretic after his death, from the annals of history. In this effort, depictions of Akhenaten and other nonconformists such as his wife and fellow worshipper of the Aten, Nefertiti, were defaced. This destruction of a person's image (or visual representation of one's name) served two purposes. First, Egyptian culture held that if one was remembered and one's name was spoken by later generations, one's spirit would survive. Second, it was also believed that a representation could serve as a repository for the being that it depicted. So, by smashing Akhenaten's statues and chiseling out his name from stone carvings, it was thought that the people were annihilating the storehouse for his soul and pulverizing his spirit. Hence, his ability to survive after death was extinguished. It was ultimate form of death.

In the end, however, Akhenaten's opponents were not able to completely destroy all of the pharaoh's visual equals. The king who went against the traditions of Egyptian religion, the professor of the Aten, has been passed down throughout time and is argued by some to be the first monotheist, presenting the precursor to Judeo-Christian theology, and the original revolutionary. Due to the uniqueness of the culture promoted during his reign, Akhenaten is frequently examined within studies concerning ancient Egypt. Ironically, if one applies the belief system of Egypt, the spirit of the pharaoh, declared a heretic and actively pursued in order to eradicate, certainly survives to this day.

One of the most important rituals within the Egyptian religion was the "presentation of Ma'at." This ritual, which is pictured in paintings from various periods of ancient Egypt's history, shows a person, most commonly the pharaoh, offering to the goddess Ma'at a feather.

At the many temples throughout Egypt, offerings were made to the patron god or goddess by presenting goods such as food to the deity's statue, which was believed to embody the sculpture. These rituals were performed three times, at dawn, noon, and sunset, in order to sustain the deity. A common theme in Egyptian artwork is displays of these offerings.

The most famous rituals were those focusing on death and the afterlife. An essential requirement for a person to continue existing after death was the spirit to have a location in which to rest; the ideal place would be the body, but in order to choose the correct location, the spirit would need to be able to recognize its own body. In order to maximize the maintenance of the physical appearance, extreme steps were taken to delay decay.

After death, the body went through a process of mummification, which involved various steps, such as encasing the body in natron. Throughout the mummification process, religious rituals were incorporated. One of the more crucial rituals included a ceremony in order to "open the mouth" so that the dead could speak and partake of food

and drink during the afterlife. Written spells would be included in coffin texts and the Book of the Dead to help the spirit circumnavigate the obstacles in the afterlife. Other objects of daily life, such as clothing, cosmetics, cooking tools, statues depicting servants, and so on, were frequently included within the burial site to aid the deceased.

The complexity of the beliefs and rituals within the culture of ancient Egypt pervaded each stage and every aspect of life, from the moment one was created, and continued after one's death. These traditions and rituals helped create continuity throughout a span of several millennia. Even though the government of the pharaohs has long since faded, the rich culture of ancient Egypt continues to live on.

Janet Balk

See also Deities of Life and Death; Depictions of Death in Art Form; Mythology; Zombies, Revenants, Vampires, and Reanimated Corpses

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Angel Makers

Angel makers are women who agree to care for foster children for a fee but neglect them until the child dies. But historically two types of angel makers can be identified. The first type of angel makers were 19th-century wet nurses who, because of their poor health and lack of child-care education, often neglected the young children placed in their care by local foundling agencies. The second type were the female angel makers of Nagyrev, Hungary, who were responsible for the death of their husbands, other relatives, and children during and after World War I. Both types put the lives of innocents at risk, and these events serve as the basis for this discussion.

Angel Makers of Officially Sanctioned Foundling Homes

Until the 19th century, children were not accorded much social or family status simply because the concept of childhood was not valued as significant. It is in this context that the first type of angel maker is best understood. This angel maker refers to alleged killers of infants. More specifically, angel makers were either women who, for a stipend, took foster children into their homes, or they were indigent women who, having lost their own infants, stayed at foundling homes, which were intended to solve the infant abandonment problem that existed throughout Europe for hundreds of years. In France, the people hired to transport babies from their home village to a distant foundling home became known as *faiseuses d'anges* or *angel makers*. This name, angel maker, was to become a more common label because of the high mortality rate during this transition to the foundling institution. The label *angel maker* also was assigned to many rural, poorly educated wet nurses, under whose charge a high rate of infant mortality was thought to occur.

Whether intentional or owing to a lack of resources, most of the children placed into foundling homes or assigned directly to wet nurses died because of either being undernourished or neglected to the extent that death occurred. Despite this high mortality, such foundling homes represented a social experiment to thwart the total abandonment of infants and laid the foundations for the modern concept of infant and child foster home care. Before the early 19th century, abandonment of children was common practice, whether by unwed mothers or by two-parent families. However, for infants abandoned during the 1830s to 1870s and prior to

the establishment of standardized child-care policies, placement into a foundling home represented a chance for survival. The placement also provided an economic opportunity for poor women who, for a fee, took abandoned infants into their homes for a short period of time. Along with wet nurses who resided in the foundling homes, these women became known as angel makers.

The motives of the individuals involved to address the infant abandonment problem were noble; they were attempting to save the lives of babies. Indeed, an officially sanctioned system for the abandonment of babies was under development in many Catholic countries, including Austria, Belgium, France, Ireland, Italy, Poland, and Portugal. These series of foundling homes were intended to support anonymous infants who had been abandoned by unwed mothers or the children of indigent families, thereby protecting the good name and social standing of the birth parents. Although abandonment had occurred for many centuries, the foundling home for abandoned infants represented a civilized response to a social problem as well as presenting a more acceptable alternative to abortion and infanticide.

An issue among contemporary analysts was whether the infant mortality rate was higher in the foundling homes or while the infants were under the care of wet nurses. In some foundling homes the death rate was more than 99%. Such statistics and the rampant rumors that surrounded the angel-makers concept led to a movement to close the foundling homes and to end policies that promoted anonymous infant abandonment—a public policy previously thought to be critical to the survival of the babies.

Angel Makers of Nagyrev

A second type of angel maker evolved during World War I (WWI), when captured Allied troops were interned in the Hungarian village of Nagyrev. In this particular village, the male prisoners (with their good looks and relative availableness) were to serve the sexual appetites of the local village women. Deprived of young village men, many of the local women entertained the prisoners in lieu of their boyfriends and husbands who were fighting on the front lines. Some of these women took many lovers and became accustomed to having several male lovers available to them at one time. Following the return of their men in the aftermath of WWI, the relationships between couples were not to be the same as before the war, and the women openly expressed their disdain for their husbands and their less-than-desirable lives with one partner. Because of the circumstances surrounding the perpetrators, the victims, and Julia Fazekas, the women's matronly collaborator, the events at Nagyrev had characteristics common to serial killing.

Although serial killers generally operate alone, among those who conspire to commit murder there are a variety of pairings involving multiple-killers. One of the most common involves females, a situation that characterizes the angel makers of Nagyrev. This group of approximately 50 malcontented housewives who, in consort with a midwife, conspired to murder their WWI veteran husbands became known as the angel makers of Nagyrev.

These village angel makers gained considerable notoriety for their murderous activities conducted during WWI and ending in 1929. During this period, the women were allegedly responsible for as many as three hundred deaths. In collaboration with the widowed midwife, these wives were able to secure sufficient amounts of arsenic from fly paper to poison their unsuspecting husbands, who they perceived to be less than desirable, sick, deformed, and domineering. Later the victims were relatives, including parents and even children who were cause for the women's anger. But the primary targets of these bored, post-WWI housewives were the veteran husbands who, because of their physical disabilities or ill temperaments, no longer served as the focal point of their wives' attention.

Dennis L. Peck

See also Abortion; Childhood, Children, and Death; Homicide; Infanticide; Serial Murder

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Angels

Angels feature in people's lives, deaths, and afterlives in the form of guardian angels, angels that meet people after death or dead people who become angels. After a period in which secularization led to an eclipse of angels, recent years have seen a resurgence of interest in angels in relation to death, for instance in popular religiosity.

By and large angels are seen as intermediate beings between the human and the superhuman worlds. Literally the word means "messenger" or "envoy" (Greek ἄγγελος: messenger; Latin *angelus*; Hebrew *mal'ach* מלאך). In a religious sense it often refers to a messenger of God or the divine. In the Abrahamic religions, for instance, angels are depicted as beings intervening between God and humankind. It always concerns mediation between the immanent and the transcendent, the here and now and a dimension beyond. Thus angels embody a key characteristic of religion: mediation between two worlds via a symbol that makes it possible to experience another world. Often this other world is the domain where the dead sojourn after they have passed on, the hereafter.

There are three main interpretations of the position of angels: (1) They are messengers who accomplish God's will. (2) They are protectors and guides to human beings in their relationship with God and the divine, who also make human contact with God possible. (3) The third meaning is a kind of antipode: the fallen angels who turned away from God and led people into temptation. In relation to death, the first meaning indicates that angels execute an instruction from God or the divine when a person dies. It pertains to how they die and live on after death. The second meaning affects the way people live, die, and live on. Angels take part in human life and help people by preparing them for death and the afterlife. After death they guide people to the hereafter. The third meaning entails the danger that in life, death, and the afterlife, people will not have contact with goodness but with evil—with the fallen angel.

Role of Angels

Angels are seen as God's helpers. In Judaism angels assist God in the Final Judgment as accusers, punishers, and angels of death. In Christianity, too, angels carry out God's will when a person dies, as described in John's Apocalypse. In Islam everyone has two angels sitting on his or her shoulder: one who records the good deeds that the person has done, the other the bad deeds. Hence the daily *salat* prayer ends with the Muslim looking to the right and to the left. When a Muslim dies these two angels appear and announce the good and bad deeds of the deceased. On the basis of their report, God passes judgment. If evil deeds predominate, the person goes to hell; if good deeds predominate, the person goes to paradise. There are also angels who guard paradise and keep a keen watch over who enters it.

Angels are helpers of human beings. In the Abrahamic religions angels play the role of protectors of human beings. They take part in their lives, deaths, and afterlives. Guardian angels—individual angels that guide and protect individual persons—date back to Judaism. Angels directly influence life and death and establish a link with God. In the hereafter they remain at people's side and guide them to paradise. The eternal afterlife with God of people who lived righteous lives is one of fellowship with angels. The righteous are waited on by angels and enjoy their company. Ultimately they may even become angels themselves. That means that they rise in the heavenly hierarchy and are closer to God. This image of angels as guides to human beings is perpetuated in Christianity and Islam, so that they form a link between humans and the divine.

In Judeo-Christian tradition there is also the image of fallen angels. Lucifer, one name for the devil, originally connoted such a fallen angel. These are beings who no longer belong to God but to evil. Since the fall of the angels, described in Genesis 6:1–4, humans have feared the evil influence of these angels. They tempt people to live unrighteously and after death to end up in the underworld rather than with God.

Attributions of Angels

The various meanings attached to angels play a major role in people's images of them, especially in the arts. Christian portrayals of angels are to be found in Roman catacombs, the earliest burial places, from the 3rd century onward. In their earliest form angels represent God, who is close to the deceased. Naturally the way angels are depicted depends on the cultural context. In Byzantine Christianity they are always winged, wings representing their association with heaven. Later the *putto* became a popular type of angel: a winged child representing innocence and purity. This latter type was particularly important at the death of children: an innocent child who becomes an angel after death and lives on as an angel. In Roman Catholic tradition the so-called Mass of the Angels is celebrated when a child dies.

Images and portrayals of angels influence the way people cope with death psychologically. The experience of transcending their bodies that dying people have in near-death experiences is often depicted as an encounter with angels. Bidding farewell while not yet fully departed from life can lead to an experience of contact with angels. According to recent research such experiences constitute an intermediate space between life, death, and afterlife, which is pertinent to both deathbed counseling and bereavement psychology. Bereaved people can establish contact with their departed loved ones in the form of angels, who represent everything the deceased had meant to their relatives.

Thomas Quartier

See also Christian Beliefs and Traditions; Heaven; Jewish Beliefs and Traditions; Muslim Beliefs and Traditions; Near-Death Experiences

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Animism

Animism has been used in two distinct theories, both of which involve particular understandings of death. The term derives from Latin *anima,* usually translated "soul" (although this term too bears a wide range of meanings in different cultures and religions). Until recently, animism has meant a belief in the existence of a component that distinguishes living beings from inanimate matter. Most theorists have postulated metaphysical rather than physical factors, but in 1708 Georg Stahl (a German physician and chemist) theorized that a physical element, *anima,* vitalizes living bodies just as another element, *phlogiston,* enables some materials to burn or rust. His theory was soon rejected, but exemplifies a widespread interest in these issues.

In 1871 Edward Tylor (often considered the founder of anthropology) adopted Stahl's term *animism* to label what he saw as the central concerns and character of religion. For Tylor, animism identifies a "primitive" but ubiquitous religious mistake, namely, "the belief in souls or spirits." He argued that *all* religions expressed the beliefs that living beings were animated by souls and that nonphysical beings, spirits of various kinds, could be communicated with. Religious believers imagine the existence of something that will survive the experience of death and, therefore, makes its possessors more than mere matter. Many think that humans alone possess souls but some attribute souls to other beings too. Tylor's "souls and spirits" thus include an expansive grouping of "entities that are beyond empirical study" (e.g., deities, angels, ancestors, ghosts). In other words, Tylor argued that such beliefs are wrong because such components of living beings and such metaphysical entities do not exist. However, he did not think these beliefs were irrational, only that people drew the wrong conclusions from their experiences of dreaming about meeting deceased relatives and from feverish encounters with strange beings. According to Tylor, religion was dying out because

proper scientific knowledge was ousting these mistaken beliefs and providing better understandings of the world. In this first version of animism, the question asked is "How are living beings different from inanimate matter?"

Because this approach focuses on what makes living beings distinctive, it involves the idea that death is a contradiction. Either beings must somehow survive death or they must cease to be anything but inert matter at death. Recent developments in the related theory of panpsychism further problematize this by questioning whether matter is in fact inert and unconscious. If matter is inherently conscious, it becomes more difficult to divide mind from matter, and perception from physicality, for example.

Since the 1990s scholars have revisited the concept of animism and offered a different interpretation. In this, the key question animists ask is "How should we live with other beings?" That is, animists are people who understand the world to be a community of persons, most of whom are not human, but all of whom deserve respect. This new theory of animism is particularly helpful in understanding the worldviews and cultural practices of indigenous people, but it also casts light on important trends in Western culture. Although this theory is not so focused on the difference between life and death, animate beings and inanimate objects, it does raise important questions about the experience of death. If this animism is particularly interested in how people should relate to others, it is necessary to ask what happens to relationships when someone dies. Also, animists who seek to respect all beings might be expected to have a major problem with killing and eating those that they claim are also persons.

Many of those who write about the new animism draw on the works of the early to mid-20th-century American anthropologist Irving Hallowell and what he learned from the Ojibwa of southern central Canada. In the Ojibwa language a grammatical distinction is made between animate persons and inanimate objects. While this is true too of the English language in which, for example, objects are usually called "it" whereas people are either "he" or "she," the Ojibwa language has a more inclusive category of persons. For example, the word for rocks, *asiniig*, carries a plural suffix, *-iig*, that indicates that rocks are in the animate category. Hallowell tried to ascertain whether this grammatical distinction made any difference to the way in which Ojibwa people actually treat stones. After all, the French language marks all tables as grammatically female, but this does not generate any gendered treatment. Hallowell asked an old man, "Are *all* the rocks that we see around us alive?" He notes that after long reflection, the old man answered, "No, but *some* are." Then Hallowell writes about the things he has been told about rocks that explain the answer. Clearly, Hallowell has asked the wrong question. The old man was not interested in a theory about whether rocks might be alive or dead, but in knowing how to relate appropriately with rocks and other beings with whom he lived. Thus, *some* rocks in the area were participants in relationship with some humans. They were perceived to have acted in ways that showed them to be persons. Also, humans had acted toward some rocks in ways that demonstrated relationship. Some of these rocks are recognized by the Ojibwa as "grandfathers," respected elders who might aid younger, less experienced or less knowledgeable persons. They are said to willingly join in sweat lodges, ceremonies in which prayers are offered for the well-being of others. Rocks are not merely aspects of the technology of the lodge, heated up in a fire and then sprinkled with water to produce steam and hence sweat; they too offer prayers and, in some cases, sacrifice their lives for others. In this and other ways, Ojibwa look for indicators of relationship rather than signs of life, whatever that would involve. The old and new approaches to animism are about quite different understandings of the world.

The new animism has been discussed in relation to people from most continents and varies enormously in the range of ways in which people claim to find relationality among particular other-than-human beings. But words for "respect" are commonplace in conversations about animism. All persons (human or otherwise) are expected to seek the well-being of other beings among whom they live. Far from projecting human likeness onto other beings as is sometimes alleged, animists understand that humans are just one kind of person in a wide community dwelling in particular places.

The problem of death is a more personal one than in the old animism: How do people deal with

the death of a relation (human or otherwise)? Many animists believe that death is a process of transformation and that people take on a new form, as ancestors or as other animals perhaps, after death. But animists are also confronted with death when they seek to eat. If all beings are theoretically alive and many are actually related, whatever species they belong to, how is it possible to eat with respect? Many cultures involve ceremonies in which the necessary violence of taking the life of a plant or animal person is recognized and some form of request and/or apology is made. Many transpolar and Siberian communities traditionally employed experts (called *angakkut* in Greenland and *shaman* in parts of Siberia and now more widely) whose job description could include apologizing for any offense caused to the other-than-human persons taken as food. Their mediation could be initiated in intense experiences in which they seemed to experience death and dismemberment by beings with whom they formed life-long relationships, reinforced each time it was necessary to sort out problems in human dealings with other beings. In some communities the shaman's job also included conversations with ancestors, but elsewhere this was a role restricted to elders rather than shamans. Ancestors are not conceived of as "dead people" but as significant people who have been through the process of death and now, although transformed, continue to offer support to their families and communities. Ancestors might manifest themselves in some animist communities by possessing people through whom they can speak and act, or by inhabiting significant cultural objects, carved stools, for example, to which offerings and speeches can be made.

Animism among indigenous peoples and in some new environmentalist religious movements (Eco-Paganism, for example) is a significant way of understanding the nature of the world. It involves not only an alternative epistemology (belief system) but also, more importantly, an alternative ontology (way of being in the world) to that of consumerist Western modernity. Experiences of death illustrate key elements of this ontology by revealing the centrality of relationality as a core component of human and other-than-human personal identity.

Graham Harvey

See also African Beliefs and Traditions; American Indian Beliefs and Traditions; Ancestor Veneration, Japanese; Australian Aboriginal Beliefs and Traditions; Death, Anthropological Perspectives

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Anniversary Reaction Phenomenon

The evolution of the notion of an anniversary phenomenon related to both bereavement and death is interesting from both a definitional as well as a historical perspective. One of the earliest mentions of the anniversary reaction phenomenon can be traced to the late 1950s at which time the concept was defined as the tendency to relive a childhood trauma at a specific time. Usually this is the date of a parent's death. This description emerged out of a study of hospitalized patients who had suffered parental losses. In later studies, however, the same phenomenon was found in a sample of nonhospitalized population.

In 1972, the term *anniversary reaction* was used to describe the emotional response of widows and widowers on the anniversary of a spouse's death. Based on research on the bereavement of 92 widowed persons, 30% had only a minimal reaction to the first anniversary of the spouse's death, 67% described a mild or severe reaction; for 3% of the cases, the response was unknown. Because the mild or severe reaction was significantly associated with the presence of clinical depression, it was proposed that the anniversary reaction phenomenon would be useful to primary care physicians as a simple diagnostic tool to evaluate the patient's distress without resorting to a lengthy psychiatric intake evaluation.

A decade later, the notion of an anniversary reaction phenomenon was established firmly in the bereavement literature and now included any

bereaved person and any anniversary related to the death that "reawakened bereavement or morbidity" in the bereaved. Two decades after the introduction of the concept, anniversary reactions were considered a normal if not essential component of the mourning process.

Also in 1972, this same concept, anniversary reaction, was used to refer to the tendency of some individuals to die on a particular date, such as a birth date or death date that had particular significance. The data used to substantiate this esoteric view have been questioned. In standard death education textbooks, an anniversary reaction refers to an increase in intensity of pain on any date associated with the deceased person.

As interesting as the definitional evolution of this concept may be, the historical context within which this concept evolved is perhaps even more interesting. To understand this context, it is necessary to return to the definition of grief as defined originally by Sigmund Freud. In his work, "Mourning and Melancholia," Freud characterized grief as painful but normal. The return to the emotional state preceding the death, however, requires work on the part of the bereaved and compels the bereaved, that is, the ego, to relinquish all energy directed toward the deceased. This argument suggests a linear process in which the intensity of the pain gradually decreases over time and eventually ceases altogether.

The notion that grief is a natural human response to a bereavement or loss and that some effort on the part of the bereaved person is required is generally accepted in the bereavement literature. The delineation between normal grief and abnormal or pathological grief, however, is probably one of the least resolved issues. Two critical issues refer to the degree of intensity and the longevity of the phenomenon.

The intensity of the emotion may render it inappropriate or abnormal. Distorted grief, for example, refers to a grief characterized by extreme anger and guilt. The timing of the emotion may render it inappropriate. This includes chronic grief, an emotional reaction that is excessive and never comes to a conclusion. On the other hand, delayed grief refers to those who may experience what is thought to be an insufficient amount of grief at the time of the loss.

Although the focus on time, intensity, and pathology continued to be of interest to early thanatologists, mitigating circumstances were gradually added to justify a grief that did not conform to the linear process proposed by Freud. For example, an anticipatory grief may precede the death when the dying process is prolonged. Delayed, continued, and/or pronounced pain may be related to the relationship of the bereaved to the deceased or sudden death as opposed to anticipated death. The anniversary reaction phenomenon, then, is one more example of the effort to normalize an apparent abnormal grief, such as the sudden reappearance of intense pain.

Through the years a number of psychological, social, and cultural factors were added to the list of factors assumed to impact the grieving process. These include circumstances surrounding the loss and suddenness of loss as well as the meaning of the loss to the survivor, prior losses, coping skills, and available resources and support. The term *complicated grief* was an attempt to eliminate the need for pejorative words such as *pathological* or *abnormal* for any grief that does not follow the linear process originally delineated by Freud. The continued use of terms such as *distorted*, *chronic*, and *delayed grief*, however, demonstrate that intensity and time continue to be major factors in delineating uncomplicated from complicated grief.

Sarah Brabant

See also Grief, Bereavement, and Mourning in Cross-Cultural Perspective; Grief, Bereavement, and Mourning in Historical Perspective; Grief, Types of

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Anorexia and Bulimia

An eating disorder can be defined as a severe disturbance in eating behavior characterized by a

lack of appetite (anorexia) and restrictive eating, or an insatiable appetite and overeating (bulimia), or some combination of these behaviors. Eating disorders are one of the contradictions of a society in which eating depends heavily on a fast food industry offering "supersized" meals as good economics and good nutrition. Eating satisfies a basic human need, but it is also subject to individual, social, and cultural influences. In a society such as that of the United States, the "supersized" culture of food intersects with and contradicts the culture of the beautiful svelte body, especially for females. How one eats, what one eats, and the frequency and quantity of food are controlled not only by individual appetite and food availability but also by factors such as family, peer, and cultural norms about food and body size. Restrictive eating behaviors and overeating are widely supported, and both can result in eating disorders that lead to health problems and, in extreme cases, premature death.

Eating disorders involve behavior that negatively affects physical and mental health; examples include excessive dieting, binge eating, and anxiety due to a negative perception of body image. The correlates of eating disorders include gender, race or ethnicity, childhood eating and gastrointestinal problems, elevated shape and weight, negative self-evaluation, sexual abuse, and a variety of individual psychologically based problems. Despite the risks, however, the practice of restricting food intake to control weight and/or body shape is followed by a substantial number of young women. The two most commonly known eating disorders are anorexia nervosa and bulimia nervosa.

The American Psychiatric Association recognizes anorexia nervosa as an abnormally low body weight (15% below normal body weight for age and height), combined with a fear of gaining weight or becoming fat, preoccupation with body weight and shape, and amenorrhea or the absence of three consecutive menses. Although anorexic patients may engage in compulsive exercising, restrictor-type anorexic patients are distinguished by their resolute refusal to eat above a bare minimum. Bulimic-type anorexic patients regularly engage in binge eating and purging. Those who suffer from bulimia nervosa engage in binge eating followed by feelings of guilt, depression, and self-condemnation. The sufferer typically engages in behaviors referred to as "purging" to counter excessive eating; this behavior includes vomiting; fasting; using laxatives, enemas, diuretics, or other medications; and overexercising.

Theoretical Explanations

Early biological-medical theories of eating disorders emphasized individual factors, tracing the origins of eating disorders to chemical and hormonal imbalances that cause metabolic changes in the body, including depression and anxiety. Psychological models similarly recognize the biological origins of eating disorders but emphasize the impact of family and peer dynamics in childhood and adolescent psychosocial development. From this perspective, young women and girls develop disordered eating patterns as a way of coping with changes in their bodies that occur within the context of stressful social interactions and developmental environments involving families, peer groups, and educational and religious organizations.

Sociocultural models trace eating disorders to factors in the wider social environment, including the media and commercial interests that create social, cultural, and economic pressures on women to lose weight in order to conform to what may represent unrealistic standards of beauty and body size. These wider social forces are believed to be at the root of most eating disorders. They are powerful forces in shaping the behaviors of young girls and women precisely because females are rewarded for thinness both socially and economically. There are, for example, well-documented biases against "fat women" in the job market. By linking women's successes, their perceived value, and oftentimes economic survival, to culturally constructed standards of beauty, women are diminished and controlled in society. Within this wider sociocultural system, Hesse-Biber notes that the mind/body dualism in Western thought, as well as capitalist and patriarchal systems, encourage females to focus on the aesthetic value of their bodies and to neglect the development of their minds. Young females with anorexia, bulimia, and binge eating disorders thus become victims of a consumer-oriented culture that emphasizes the maintenance of a weight that lies below standards of good health.

Incidence and Prevalence of Eating Disorders

Estimates of the incidence and prevalence of eating disorders vary, no doubt because those who suffer from these disorders are often reluctant to reveal their condition. Despite the paucity of data, most of those who have researched or treated eating disorders agree that the incidence and prevalence of both anorexia and bulimia have increased markedly during the past 50 years. Some of this increase may be related to more awareness, hence greater identification of disordered eating.

Based on the available data, eating disorders are most common among young, middle- to upper-middle-class white women who live in more affluent countries. Epidemiological studies of anorexia in Western industrialized countries suggest an incidence of between 8 and 13 cases per 100,000 persons per year, but only an estimated 5% to 15% of these anorexic or bulimic individuals and an estimated 35% of those with binge eating disorders are male. Bulimic patients outnumber anorexic patients by at least 2 to 1. The prevalence of partial or restrictive eating disorders is at least twice that of full-syndrome eating disorders. Longitudinal studies suggest a progression from less to more severe eating disturbances, with normal dieters occasionally becoming pathological dieters who occasionally progress to partial or full-syndrome eating disorders. Although eating disorders are most common among young middle-class white females, anorexia is increasingly more common among young black and Hispanic women and girls.

Mortality Rates

The crude mortality rate among anorexics is estimated at 5.6% per year, approximately 12 times higher than the annual death rate for all causes of death among females aged 15 to 24 in the general population. Approximately 10% of people diagnosed with anorexia eventually die due to eating disorder–related factors. As self-starvation is a core feature of anorexia, high mortality rates are expected. However, anorexics are more likely to die from related medical complications, such as heart attack and electrolyte imbalance, than from malnutrition. For those with bulimia nervosa, the most commonly reported causes of death are car accidents and suicide. Among anorexics suicide is the second leading cause of death.

Attempted and Completed Suicide

It is estimated that 20% of patients with anorexia and 25% to 30% of patients with bulimia attempt suicide. The majority of studies find no difference between frequencies of suicide attempts among those diagnosed with anorexia as compared to bulimia. Other researchers do, however, report lower rates of suicide attempts in persons with anorexia than bulimia, with individuals classified within the binging/purging subtype of anorexia more likely to attempt suicide than those placed in the restricting dieter subtype.

Although suicide is common among anorexic sufferers, the number of completed suicides in persons with bulimia is negligible by comparison. The crude suicide mortality rate reported for persons with anorexia ranges from less than 1% to 5.3%. However, actual rates of anorexia-related suicide may be higher. Clinical correlates of suicide include purging behaviors, comorbid disorders such as depression and substance abuse, physical and/or sexual abuse, as well as other individual characteristics. For example, the best predictors of mortality among anorexia and bulimia sufferers is the extent of prescription drug abuse, illegal drug usage, and alcohol abuse.

Treatment Options for Eating Disorders

A range of options are available for treating eating disorders. However, for a number of reasons little research exists from which to document the success of these treatments. Treatment plans include medication, nutritional counseling, and individual, group, and/or family psychotherapy. Some patients also may require hospitalization or treatment in specialized treatment centers designed to address malnutrition, weight loss, and self-esteem issues. But individuals with eating disorders rarely seek treatment; they are often in denial and refuse to accept the serious nature of their eating problems.

Although anorexia nervosa is difficult to treat, some researchers suggest the use of antidepressants, antipsychotics, or mood stabilizers may be effective in alleviating mood and anxiety symptoms. However, others suggest that antidepressants are not an effective treatment for preventing patient

relapse. Most importantly perhaps no medication has been shown to be effective during the critical first phase of restoring a patient to healthy weight. Individual, group, and family-oriented psychotherapy may address some psychological issues while others suggest that family-based therapies are effective in assisting anorexic adolescents in working toward recovery. Others note that medical attention and supportive psychotherapy designed specifically for patients with anorexia is more effective, but whatever the treatment chosen its effectiveness may depend on case-specific criteria. Moreover, female testimony indicates that recovery is a slow process; improving body image and feelings of self-worth is an ongoing struggle. Treatment and prevention techniques that take a cultural approach to eating disorders show promise.

Similar to treatment for anorexia, treatment for bulimia depends on individual need. In an effort to reduce or eliminate binging and purging behavior, bulimic patients may undergo nutritional counseling and cognitive behavioral therapy or be treated for depression and/or anxiety. Medication also may be helpful in reducing binge-eating and purging behavior, reducing the chance of relapse, and improving eating habits. Again, recovery is a slow, ongoing process. Treatment and prevention approaches based on feminist therapies and media-awareness training show some promise.

Finally, the effective treatment of eating disorders requires therapists grounded in knowledge and techniques unique to these disorders. However, even the best therapists and health care givers are treating only the symptoms of culturally produced behaviors. Actions that seek to establish gender equality and altered representations of the ideal body shape, weight, and appearance will ensure a healthier population.

Vicky M. MacLean and Melissa Sandefur

See also Acute and Chronic Diseases; Adolescence and Death; Gender and Death; Suicide; Suicide, Counseling and Prevention

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Apocalypse

Apocalypse is defined as a prophetic revelation. It is a description of the battle of Armageddon, the battle of good versus evil, as revealed in the book of Revelation of the New Testament of the Bible. In the Christian scriptures, Apocalypse means revealing or uncovering. The Apocalypse can be interpreted as a prophetic disclosure, as a lifting of the veil to reveal the true and living God in the fullness of truth. It can also be interpreted as the return of Christ and the defeat of His apocalyptic enemies.

Apocalypse is an important statement of faith that evolves throughout Hebrew life and in the writings of the early Christians. It is a vivid expression of eschatological teachings about *last things*, it is vindication for all who have trusted in God against the forces of evil and the forcing out of evil

to its final destruction, and it is the fulfillment of the establishment of the Kingdom of God.

The Concept Apocalypse as Sociocultural Symbol

As a cultural theme for literature and the media, apocalypse has been a popular source for many movie plots, movies like *Apocalypse Now, Resident Evil: Apocalypse*, *and Apocalypse II: Revelation*. Created with gimmicks, violence, and the battle between the forces of good and evil, these movies loosely speak of social instability, disasters, anxiety, and expecting God (or the movie star) to rise up and defeat the enemies. For some, such apocalypticism is a form of entertainment; for others it is considered a religious affront. Discussions of Apocalypse have divided religions, denominations, congregations, and families. Yet it remains an essential statement of faith and hope for many, with inclusion in religious creeds.

Apocalyptic Groups

In the contemporary experience, some people turn to the apocalyptic concept after catastrophes. For example, in the aftermath of Hurricane Katrina, some may have asked, "Is this the time?" There also are religious leaders who play on such fears and the despair of others to align potential membership with apocalyptic doctrine as the group leadership and congregation define it. Apocalyptic groups may emerge and then disappear, but they often share the common theme of believing that the future will lead them to a higher level of existence.

Among the more recent and notable of such groups was the Branch Davidian cult, a group from Waco, Texas, led by David Koresh, which came into direct violent conflict with U.S. Federal Bureau of Investigation in 1993. In 1997 members of the Heaven's Gate cult, led by Marshall Applewhite and Bonnie Nettles, committed suicide. Another such group was the People's Temple cult led by Jim Jones; the group migrated from the U.S. state of Indiana to California and then to Guyana in South America, where more than 900 members died, most by suicide. The leadership of each of these and similar apocalyptic groups promote the belief that the world will end on a certain date or at the time of a certain event, such as the appearance of the Comet Hale-Bopp on or about March 26, 1997. Contrary to most biblical teachings, or interpretations, many biblical scholars note that the Bible indicates that only God knows the exact day and time of the apocalypse.

The Biblical Approach to Apocalypse

The concept Apocalypse offers a dimension of hope, justice, and relief to an oppressed people. The Hebrew people faced rejection, war, oppression, and exile, much like the early Christians. For early Christians who worshipped in secret and faced certain death if discovered, the knowledge that Jesus would return soon and defeat all of their enemies was a measure of hope and vitality.

The Bible is rich in apocalyptic writings. Ezekiel, Isaiah, Joel, Zechariah, and Daniel were hotbeds of imagery that guided Judaism and were quickly adopted by the early Christians. There also were numerous writings in the intertestamental period that followed the closing out of the Old Testament and intervened before the start of the Christian story. Daniel spoke of the three who survived the fiery furnace. Joel spoke of a phoenix rising from the ashes. Ezekiel spoke harsh words of judgment to the Israelites in laments, warnings, and woes. In the New Testament, the four Gospels offer apocalyptic sketches, and the last book in the New Testament, the book of Revelation, focuses on the Apocalypse almost exclusively.

The book of Revelation (The Apocalypse of John) represents a pastoral attempt to bring hope and timely intervention (by God) into the violence of religious wars and other destruction. Some interpret this book literally as a specific script, word for word, of what the Apocalypse will be. Others assert that this book was written in a language based on the fear of further persecution.

Despite the many interpretations and divisions within the Christian church, the Apocalypse is often viewed as a doctrine of comfort and an invitation to bring people closer to God. Providing religious meaning to the man-made tragedies and natural disasters of life brings clarity for many to at least live with that which appears unbearable. The implication is that tragedy is an appropriate pathway to drawing closer to God through the

destruction of that which comes between God's love and, ultimately, human need.

Richard B. Gilbert

See also Armageddon; Christian Beliefs and Traditions; Eschatology; Resurrection; Symbolic Immortality

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Appropriate Death

Death is considered an appropriate occurrence of human experience when it is not out of place according to personal and cultural norms. Whether regarding our own death or the death of others, we always refer to a complex aggregate of many ingredients or criteria of appropriateness when we label a death. It is a person's concrete way of dying but also his or her life (one's age, self-fulfillment, and morality) that are concurrently referred to as quintessential conditions of appropriate death. Therefore, almost no death is experienced as fully appropriate.

Concept

The term *appropriate death* was introduced in the 1960s by clinicians. Their aim was to improve the care of the dying in a time when most people were in denial about death and talking about good death, by consequence, would be contradictory. Appropriate death has a more neutral connotation: It is a death that is to be accepted, as in the final stage of dying described by Kübler-Ross. Still, substantial confusion exists in the end-of-life literature on how to use the term *appropriate* and to differentiate it from other terms, including *healthy, peaceful,* or *natural*.

It is essential to recognize that the idea of appropriate death also guides, albeit as an unspoken or implicit label, how we all think, feel, and act in any experience of death and grief. Mainly scholars and practitioners of care for the dying use the concept of appropriate death in explicit terms, often with reference to a phrase of the psychiatrist Avery Weisman: It is "a death that someone might choose for himself had he a choice."

The concept is clearly relational: It is the social context that makes a specific death into an appropriate death and, even within the same time and space, a death can simultaneously be appropriate for some and inappropriate for others. Therefore, it is necessary to establish who defines appropriate death, that is, whether death is considered appropriate by the dying person, his or her family, physician, religious leader, or counselor. Moreover, the idea of appropriateness may refer to one's own death or to the death of another. Finally, it is important to ascertain whether appropriate death is related to the process of dying or to that of grieving.

Dying

In 1961 psychiatrists Avery Weisman and Thomas Hackett described four principal requirements of what they defined as appropriate dying. One who dies should have a reduction of conflicts; as little physical, emotional, and social pain as possible; a continuation of significant relationships; and a fulfillment of prevailing wishes. Weisman noted that although such conditions are almost beyond reach, it is still important to at least aim for a death that is as humane and dignified as possible.

The social perspective of appropriate dying is historically variable. Until a few generations ago, it was considered appropriate to die a saintly or religious death. It was associated with the last rites and with the presence of family and clergy at the deathbed. Such representation is still vivid for those who believe in a hereafter, and it is also popular in movies and other art forms. Yet, from the 18th century on, it was the doctor who became the practical manager of a profane death and who decided at what moment death had taken place. Whereas death in the 19th century was linked to moral judgment, in the 20th century evil was no longer connected to hell and sin, but rather to

illness and physical pain. The task of the hospital doctor was to deliver appropriate death by alleviating pain, rather than purifying one's soul. Finally, since the rise of palliative and hospice care and psychological discourses, natural death without protracted medical intervention is regarded as most appropriate.

Both euthanasia and suicide can be viewed as appropriate death for the person who wants to stop living, but suicide especially is regarded as traumatic and inappropriate. The appropriateness of euthanasia is still a matter of contentious debate. For instance, there is no agreement on whether euthanasia, commonly linked with unbearable physical pains, can also be the release from psychological problems. Further, appropriateness is questioned when the patient's autonomy is unclear, as is the case with children and people with dementia. Conversely, suicide, in some situations, is labeled appropriate death when it involves self-sacrifice or when it is considered a heroic act in time of war or when someone dies in the act of protest or nonviolent resistance. If death, however, is unwanted and occurs in a violent manner, it is typically not viewed as an appropriate death.

Age

Death at old age is typically considered appropriate death, as it is considered the natural and hence acceptable outcome of life. Young people often alleviate their fear of death, albeit unconsciously, by assuming that old people are closer to death than they are. As a result of improved standard of living (including food quality, personal hygiene, medical care, and safety) life expectancy has greatly increased. For that reason, becoming 80 years old is a normal expectation for the present generation. Since life is prolonged, dying is generally pushed forward, distanced, and associated with old age. Appropriate death is universally believed to follow the order of generations. As such, it is regarded as a natural law that parents should not survive their children.

Whereas dying at a young age tends to be less easily accepted and received as an unnatural fact, deaths at old age, in contrast, are typically romanticized through natural metaphors. Sayings like "he died in the fall of his life" and images of falling leaves on obituary cards affirm dichotomous thinking of life and death, spring and fall, youth and old age. Another consequence of linking appropriate death to old age is that staff members of a hospital may not give as much attention to elderly persons with a terminal illness as to children and youngsters who are considered to be heading for an inappropriate death.

Self-Fulfillment

An important principle that directs responses to dying and grieving in modern Western society is the notion of self-fulfillment. If one's life is thought to be complete, the individual is considered to have reached a stage where one is happy with life's accomplishments. In general, a long life of many memories is believed to exemplify the appropriate death while preparing the dying person to pass away. From this perspective, a person who is about to become a parent or has just been promoted to a sought-after position would not die an appropriate death.

It is sometimes argued that when death is seen as the definitive end of life with no prospect of an afterlife, more pressure is put on fulfilling one's life in the here and now. It would then be not so much death as such, but rather death before a full life has been lived that is feared. However, societies do not offer a consensus on what the goal of human life then would be. Life values are more than ever primordially derived from the authority of the self rather than from membership of communities such as the family and the church. Therefore, what makes a fulfilled and happy life for one person may not do so for another. Further, even or especially after a full and happy life, it would be reasonable to want to continue good times. Death after a so-called full life can be experienced as an intrusion for the family and friends of the deceased person, especially where the decedent played an important social role in the lives of relatives while living.

Morality

The label of appropriate death may also be morally inspired. For instance, in Catholic European contexts appropriate death followed a moral life of values such as piety, modesty, and selflessness. Until the 1950s local priests, writing the text for the obituary card to be distributed in their parish,

constructed the death of children and youngsters as a proper death, as they were regarded to follow a "life of devotion, guided by the light of the Holy Spirit, and inspired by the great love of God and fellow humans." Young people were expected to be prepared to die after a Christian life that had given them the key to the Gates of Heaven. From such a moral point of view, death at a young age was thus to be accepted even though the person had still a life ahead.

In particular contexts, death can also be constructed as the appropriate punishment for a life that is not judged moral. In some states and countries, the death penalty is considered appropriate by the law as punishment for certain categories of crime. However, as debates and protests prove in the United States, such moral evaluation of appropriateness is never without resistance. The same is true for the issues of abortion and euthanasia where religious groups oppose those who favor autonomy and decision making by individuals and doctors according to the specific nature of a situation. The idea of autonomy, on the other hand, is also the underlying principle of appropriate death when individuals are found responsible for unwanted death. For instance, a culture that glorifies health and fitness is not indignant about the death of a man who died from lung cancer when he was addicted to cigarettes.

Jan Bleyen

See also Aging, the Elderly, and Death; Awareness of Death in Open and Closed Contexts; Defining and Conceptualizing Death; Denial of Death; Euthanasia; Good Death; Kübler-Ross's Stages of Dying; Life Review

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Ariès's Social History of Death

Social attitudes and cultural responses to death have varied over time. Nowhere is this change more apparent than in the social history of death documented in the work of the French historian Philippe Ariès. Ariès's analysis of the social meaning of death in Western societies reveals that from the 18th to the mid-20th century in particular a cultural shift from collective social rituals of mourning to a less visible individualized appearance of death had taken place. Ariès argued that in the contemporary Western experience, death has become invisible and is not a topic that should be a matter of public discussion. Ariès's social history of death demonstrates that the historical public attitude toward death changed from that of a "tamed death," the view that death is open and should be anticipated and prepared for, to the attitude that death is forbidden, the modern view that death is a nondiscussed topic.

It was this thesis promulgated by Ariès of a forbidden public view of death that led to an increasing interest in the teaching and a proliferation of research in the area of death and dying that began during the early 1970s. Inspired by the meticulously documented work of the French historians Ariès and Michel Vovelle, during the final 3 decades of the 20th century and well into the 21st century, scholars and practitioners alike have addressed this important de-emphasis of death-related mourning rituals and the evolving role of hospitals, nursing homes, hospice organizations, and even funeral homes in the dying and death experience.

The published work of the French historian Ariès provided significant evidence that supported the common belief among intellectuals and scholars

that a profound cultural meaning had been lost in that the physical act of death and the fact of death were disappearing from public view. In Ariès's historical accounts covering 1,500 years, death indeed ended up being "invisible" and "wild," in contrast to its earlier "public" and "tamed" counterpart. Sorting out the chaos of the past, Ariès's vivid and comprehensive narrative of shifting attitudes toward death inspires many researchers to this day. However, since both the discipline of history and the social context of dying and bereavement have changed since his death in 1984, Ariès's history of death has recently also been criticized and supplemented.

History of Mentalities

Being a political reactionary and remaining long without academic position, Ariès remained in the ranks of French historians until the 1960s. Although he called himself a "Sunday historian," he not only gained a broad readership but also stimulated scholars to break new grounds. Touching upon formerly unexplored topics, such as the child, death, or sexuality, and using new approaches to the relationship between private and public life, Ariès indeed came to be respected as a pioneering and provocative figure in historical scholarship. He specifically contributed to a cultural approach within the Annales School, whose practitioners' aim was to lay bare underlying and long-term structures in history. For Ariès, these structures consisted not so much of socioeconomic realities, as stated by many of his contemporaries, but rather of *mentalités*: mental lives and attitudes that tacitly shaped the daily lives of particular groups or whole societies. His attempt was to grasp these fundamental aspects of the human experience that until then were largely considered without a history.

His traditionalist sentiments, on the one hand, and interests in demography, on the other hand, stimulated Ariès to study the private and everyday lives of ordinary people, hence revealing major shifts between premodern and present lifestyles and values. According to Ariès, the current day should serve as a point of reference to look at the past in order to understand the differences between now and then. This was also the case when he wrote his history of death.

The Modern Problem of Death and Grief

From diverse authors and publications in the 1950s, 1960s, and 1970s, Ariès learned how both dying and grieving had become new problems of the human experience. For instance, Ariès cites psychiatrist Elisabeth Kübler-Ross, who caused a shock with her best-selling book *On Death and Dying,* mirroring the "humane" and "natural" death she knew from her childhood to the later controlled and institutionalized dying at the hospital. Other sources of inspiration were psychologist Herman Feifel, sociologists Barney G. Glaser and Anselm L. Strauss, and philosopher Ivan Illich who shook up intelligentsia with their outcry against the alienation of terminally ill patients. Neither was Ariès alone in his concern about the estrangement of grieving survivors. Already in 1955, anthropologist Geoffrey Gorer had stated that the 20th century no longer gave free rein to death, just as the Victorian Age had banished sexuality. Without any ritual scripts at the hour of death, bereaved people were thought to be let down, by consequence, distressed by psychological problems. Likewise, Ariès was impressed by *The American Way of Death*, written by investigative journalist Jessica Mitford, who denounced the insensitive profit seeking of mala fide funeral undertakers.

Among others, Ariès found that the apparent medicalization and commodification, but also the social processes of technologization, secularization, and individualization, considered typical of the modern society he was living in, had pernicious influences on the experience of death, dying, and grief. Once human beings were surrounded by a less natural world, once they could no longer fall back either on a shared system of meaning-making, as formerly offered by the churches, or a sense of security, previously served by a community like a neighborhood or parish, they were just on their own in their encounter with death.

Before he wrote his *Western Attitudes Towards Death,* a small book that brought together a series of lectures from 1974, Ariès was already famous for his history of the child and the family: In his *Centuries of Childhood* he applied visual evidence to claim that only in the 17th century was the concept of "childhood" originated. *L'homme devant la mort* (literally "Man in the Face of Death"), an ambitious book of more than 600 pages published

in 1977 and later translated in English as *The Hour of Our Death*, offered a challenging overview of attitudes toward death from the Middle Ages to the present.

Issues

Ariès organized his monumental book, *The Hour of Our Death,* about changing mentalities around four psychological issues: awareness of the individual, the defense of society against untamed nature, belief in an afterlife, and belief in the existence of evil. Drawing on many different sources, including literary, liturgical, archaeological, and iconographic materials, Ariès thus constructed sequential attitudes toward death: the tame death, the death of the self, remote and imminent death, the death of the other, and the invisible death.

The Tame Death

This first model describes death as a simple, familiar, and taken-for-granted human experience. According to Ariès, in premodern Western societies death was accepted as an inevitable part of life. Mainly building on passages from literature, such as the romance of chivalry, Ariès constructs this attitude as one without a clear history: It describes the human being, basically situated in archaic or so-called primitive societies, who knows death is about to occur and who is surrounded by a community. In the experience of tame death, the dying person controls the act of dying, resignedly accepts the nearing death, and passes away restfully facing heaven.

The Death of the Self

The first violation of this tamed death occurred during the late medieval times when the dying person became increasingly concerned about his own destiny in the hereafter. Especially for the elite, life became an exercise in redemption and the *ars moriendi* (art of dying) under the wings of the Church. Death became "one's own death": The acceptance of a natural order and collective fate of humanity was put under pressure by a growing attention for individuality and one's own salvation. The act of dying hence became the quintessential moment of an emerging self-consciousness.

Remote and Imminent Death

By the end of the 16th century a reversal of death started to appear. This is the real turning point of the long-term history of mentalities, not yet included by Ariès in his *Western Attitudes Towards Death:* Whereas before, death had been immediate, familiar, and tame, during the Enlightenment it gradually developed into a distant, secret, and violent phenomenon. By its remoteness death became fascinating and often even erotic. It might seem a surprise that such "savagery" returned in the Age of Reason. However, it was exactly the faith in progress and its triumph over nature that confused the traditional barriers of life and death, hence evoking the fear of being buried alive.

The Death of the Other

In the 19th century a new feeling came about alongside new conceptions of the family: In the hour of death, the focus was no longer on one's own ending but on the death of the other. Death, on the one hand, was increasingly experienced as a problematic rift between the dead and survivors. Grief, on the other hand, was no longer ritually constrained by the community; it became "hysterical" and "insane." Excessive expressions of emotion pointed at the difficulty of the bereaved to accept the death of intimate ones. The memorializing of the dead endorsed them with a sort of immortality; the grave became the site where the dead were visited as if still alive. No longer associated with evil but with beauty, death became romanticized.

The Invisible Death

Finally, in the beginning of the 20th century, a psychological climate arose in which death was radically distanced from the public area thus becoming "hidden" and "reversed." In the hospital, the dramatic act of dying was segmented in several small steps and, therefore, disappeared. The familiarity with funeral rites diminished; tears became morbid because they disturbed the illusion of happiness—since the Enlightenment the breeding ground of the taboo. Hence, grief expressions were shameful and had

to happen secretly. Mourning attire vanished from street scenes and children were protected from sorrow. With the rise of cremation, the dead could no longer be visited at the gravesite or be memorialized. Because of the loss of traditions, Ariès stated, modern society had trouble in facing mortality.

Relevance and Critiques

Ariès's social history of death has been of great importance to a broad audience of readers, including scholars. Never before had the Western history of death been captured in such a precise way. His history is still challenging and still makes excellent reading for its original interpretations of materials and the iconographic culture of death. Nevertheless, the writings of the "historian of death" have also been questioned.

Although his discussions of especially French and medieval sources are thorough, Ariès has been blamed for generalizing and extrapolating his empirical data. Furthermore, because it downplays both the active role of individuals and the dynamics of social practice, the concept of "mentalities" is no longer in vogue among historians. Also, his hydraulic metaphor of emotions—the underlying model of his long-term history, which takes emotions as natural liquids that are let out and controlled in culturally specific ways—has been superseded.

Still, it was his depiction of modern death and grief ways, in contrast to traditional ones, that has especially been the subject of attention and controversy. Tamed death is now being deconstructed as a romantic and nostalgic imagination of a mythical past and a noble savage. According to recent social studies, death and grief rituals have not disappeared or grown poorer, as stated by many cultural pessimists including Ariès, but rather they have changed and moved to other places. Because present ways of living and cultural contexts are radically different from medieval ones, it is perceived evident that people also die and mourn differently. Indeed, since the publications of Ariès, social settings of dying and bereavement have changed. Diverse new initiatives came into being, including palliative care for the dying and support groups for grievers. The amount of research, education, and information on dying and grieving has expanded. In other words, the loss of one tradition, such as the wearing of mourning attire, does not point at the loss of death culture as such, but rather at its transformation.

Also in premodern social contexts, the death of a loved one could be a troublesome event, and it is also nowadays dealt with in meaningful ways. Hence "good death" and "appropriate grief" cannot be primordially equated with one content, form, and context—such as Ariès's model of tamed death—but are always socially constructed. How a society ritually deals with death and loss, and hence makes sense of them, is historically variable. Before the 1960s, particular types of death and grief could be "disenfranchised." For instance, as long as religion permeated all aspects of life in Western Europe, stillbirth and suicide were dealt with rather secretly: Public expressions of grief were considered improper when death was considered God's will or a violation against it. From such a perspective, death cannot be understood to have had one linear narrative of downfall. It does not have one history, but rather it has multiple histories.

Jan Bleyen

See also Appropriate Death; Defining and Conceptualizing Death; Denial of Death; Disenfranchised Grief; Funeral Director; Funerals; Medicalization of Death and Dying

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Armageddon

In the New Testament, the book of Revelation, chapter 16, verse 16, is a reference point for the concept of the battle at the mountain of Armageddon. Armageddon (*Harmagedon* in Greek) refers to the big war that will take place on the great day of God. Armageddon is the final battle between good and evil, the ultimate triumph of Christ. Defined in the Hebrew as *har* (mountain) and Megiddo (city in ancient Palestine), the concept Armageddon, referred to in the Old Testament as a military stronghold, is based on two verses from Christian scripture that have emerged as a part of Christian eschatological beliefs. In the Bible, mountain is symbolic of a kingdom, and the battle at the mountain of Armageddon will bring about God's kingdom.

For Christians, Armageddon is the final battle among all the armies of the world; it is the ultimate battle between good and evil. For some, Armageddon is dramatic and it is an imminent event that unites Christians. For others, Armageddon is simply part of the biblical history that represents an exaggerated series of statements from another time period that have been stretched beyond reality.

Religion and the Armageddon Concept

Biblical topics have often been cause for debate if not some confusion. Clearly, the Bible was written at a time when the church was in its infancy, the membership was sometimes persecuted, and believers anticipated relief from persecution with the Second Coming of Christ.

This emphasis on war and victory of good over evil, in which good will conquer evil, finds further support in brief references in the Old Testament, namely Judges 5:19 and 2 Kings 23:29. Many biblical scholars adamantly believe the battle at Armageddon will fulfill biblical prophecy.

Many religious thinkers insist that if Armageddon is referred to in the Bible then it is true, thus making this truth imperative for belief, and to question the veracity of the battle of Armageddon is to question other biblical writings. Armageddon also represents a political and religious affront in the Middle East because, it is argued, Western nations tend to offer support to Israel because of the religious symbolism Megiddo holds for Christianity as the site of the final battle. This pro-Israel orientation represents a juxtaposition between religion and political issues. Thus, the chasm is increased between the Christian community, the Middle East, and other religions of the world.

The whole concept of the war of Armageddon moves some individuals away from God because it gives them cause for confusion and despair. On the other hand, there are those Christians who argue that the war of Armageddon is the fulfillment of God's promise to return and claim His believers unto Himself.

Signs of the Coming of Armageddon

The Bible details many signs and wonders that must come to pass prior to the battle at Armageddon. Some religious teachers assert that man-made disasters such as the Holocaust, the terrorist attacks of September 11, 2001, as well as natural disasters such as earthquakes, tsunamis, and hurricanes are prophecies of Armageddon. Fictional writings, such as *The End of Days: Armageddon and Prophecies of the Return* as well as the *Left Behind* series of books that was made into a movie by that same title, promote a similar theme. Many religious and biblical teachers insist these events are prophecies that need to be heeded and fulfilled before the occurrence of the battle at Armageddon, asserting that they are a sign of God's imminent return.

The book of Revelation was said to have been written by John who, because of his Christian faith, was exiled to the Roman penal colony at the Island of Patmos. The book of Revelation is an account of visions revealed to John by God in symbolic and allegorical language borrowed from the Old Testament, especially the books of Ezekiel, Zechariah, and Daniel. The symbolism expressed in Revelation was apparently popular at the time. The book of Revelation was created amid a time of crisis, yet its central message to Christians holds true today: Stand firm in the faith, God will return, and continue to persevere in hope despite a troubled world.

Richard B. Gilbert

See also Apocalypse; Christian Beliefs and Traditions; Eschatology in Major Religious Traditions; Last Judgment, The

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Art of Dying, The (*Ars Moriendi*)

Ars moriendi, literally "art of dying," refers to a genre of Christian devotional literature that enjoyed widespread popularity across Europe from the 15th to the 18th centuries. These works had a fundamentally practical orientation, aiming to advise the dying regarding how they might avoid despair at the end of life and thereby avoid the damnation believed to await those who faltered in faith. Over time the genre expanded its focus beyond the deathbed by describing also how one's manner of dying was often decisively affected by the habits of living developed over one's lifetime. Scholars of religion study the ars moriendi tradition because it is one of the great genres of Christian devotional literature, but these writings appeal to a broader audience because they offer glimpses of what the experience of dying was like in Renaissance Europe. The ars moriendi reveal what Europeans from this era saw to be the central existential challenges of dying, and provide detailed accounts of their strategies for meeting those challenges.

Origins of the Tradition

The roots of the ars moriendi tradition can be traced to two anonymously written works: the *Tractatus artis bene moriendi* and a shorter, later work known simply as the *Ars Moriendi,* which combined an abridged version of the *Tractatus* with a series of woodcut illustrations depicting the struggles of the dying against various temptations. Both works enjoyed enormous popularity during the 15th and early 16th centuries. The *Tractatus* was written circa 1415 and later translated into every European language. The influence of these works extended far beyond their direct readership because many preachers drew heavily upon them when offering sermons on preparing for death. For example, Girolamo Savonarola preached *Predica dell'arte del ben morire* to large crowds in 1496. It was later published and circulated among clergy who put it to further use in their own preaching.

Historical Context

The popularity of the ars moriendi can be explained in part by the fact that interest in death was already very high before these works were published. Plague, warfare, and food insecurity had long made clear the constant proximity of death, and reflections on the power of death were common in popular religious practice. It was typical at this time for preachers to exploit their listeners' fear of death in order to move them toward religious conversion. The *Danse Macabre,* in which a personification of death (usually a cadaver) led people of all classes as captives, was a popular example of the times' fascination with death.

Tone, Structure, and Content

In contrast to the often graphic, macabre treatments of death that predominated at the time, the *Tractatus* strikes a consolatory tone. It does not represent death as something natural or unequivocally good, but its focus is not on death's horrors. Instead, the *Tractatus* portrays dying as a final, challenging task that one can do well or poorly. The deathbed provides the setting for a battle between God and Satan for possession of one's soul. The block prints of the shorter *Ars Moriendi* depict this battle vividly. In an emblematic illustration, a man lies upon his deathbed, surrounded by angels and friends on one side and demonic creatures on the other. Thus the dominant image of dying in the *Ars Moriendi* is that of monumental struggle, but a struggle against spiritual and moral weakness rather than against disease or death itself.

The central piece of advice in the *Tractatus* is to endeavor to die gladly and willfully. The text

assumes dying to be a painful, frightening experience, but attempts to soften these facts by putting them into a Christian context. The pain of death is recast as a just punishment for sin sent by God. The reader is asked to ponder how even weeks of suffering on one's deathbed would pale in comparison to the torments of eternal damnation that would result from failing to die gladly. One should surely prefer to accept physical punishment from God in dying rather than experience God's everlasting vengeance beyond the grave.

The *Tractatus* comprises six chapters:

1. General advice and sayings from Christian and classical sources regarding how to die well
2. Advice about how to overcome the temptations of unbelief, despair, impatience, pride, and avarice
3. Interrogations that encourage the dying to acknowledge their sinfulness, promise to repent, and affirm their faith in God's mercy
4. Prayers and instructions that direct the reader to imitate the way in which Jesus died (e.g., by commending one's soul to God, by dying willfully, and so on)
5. Advice to those at the bedside
6. Prayers to be said at the moment of death by those present at the bedside

Throughout these chapters, the discussion of how to face the trials of death is somewhat sterile and mechanical. The reader is not moved to faith or patience or hopefulness so much as told of the importance of those dispositions. The author of the *Tractatus* sees a sophisticated understanding of Christian faith to be unnecessary for salvation; instead, the worth of one's faith was measured by a willingness to affirm the creed and the teachings of the Church.

It can be inferred from the *Ars Moriendi* that dying was a decidedly public affair in 15th-, 16th-, and 17th-century Europe. The *Tractatus* assumes that friends play a vital role in helping a person die well. They help the dying leave this world willingly by assisting them in setting their affairs in order: finalizing a last will and testament, facilitating reconciliation between the dying and estranged relations, and so on. In addition, friends were to nurture the spiritual well-being of the dying. The *Tractatus* instructs those at the bedside to recite the creed in a loud voice whenever the dying falter in faith, recommends holding a cross before the eyes of the dying as a means of encouragement, and prescribes the recitation of many prayers.

Evolution of the Ars Moriendi Tradition

Erasmus: From Ars Moriendi to Ars Vivendi

During the 16th century, some of the brightest theological minds of the time contributed to the growing corpus of the ars moriendi tradition. Desiderius Erasmus was the first eminent theologian to improve upon the *Tractatus*, publishing *De praeparatione ad mortem* (Preparing for Death) in 1533. He dramatically improved upon the often artless prose of the *Tractatus,* and made a major contribution by highlighting the importance of the art of living well (the *ars vivendi*) as a means of preparing to die well. Erasmus's decision to focus heavily on the ars vivendi set a trajectory that would be followed by most subsequent works in the ars moriendi tradition.

Whereas the author of the *Tractatus* was certain that a person's eternal fate was determined by his or her disposition at the moment of death, Erasmus believed that no one should be judged by their manner of dying. Nevertheless, he devoted considerable attention to dealing with the difficulties of the deathbed; however, he did so not to provide a recipe for attaining eternal salvation. Instead, Erasmus's aims were to provide comfort and to lead Christians to see preparation for death as an opportunity for spiritual renewal throughout life. He sought to provide comfort primarily by suggesting that if one could learn to put one's trust entirely in divine mercy and compassion, the fear of death would melt away.

Erasmus offers a clearer portrait of the psychological torments suffered by the dying than can be found in the *Tractatus*. He composed a dialogue in which the devil taunts the dying, playing upon their fear of the unknown and upon the Christian notion of God's justice: How could a just God admit such an imperfect person into paradise when that person certainly deserves punishment? Erasmus suggested that the key to helping the dying meet

the temptations of the deathbed was to find a prudent spiritual counselor (usually a priest, but occasionally a wise friend) who would offer consolation while avoiding false flattery. By finding such a balance, the dying could learn to repent of the mistakes they had made during life without slipping into despair.

Jeremy Taylor's Holy Living and Holy Dying: Pinnacle of the Tradition

As the ars moriendi tradition began to flourish after the time of Erasmus, the Protestant Reformation divided Western European Christianity. The ars moriendi enjoyed enormous popularity among both Catholics and Protestants. Tracts were authored by theologians from across the spectrum of Christian denominations. Among the notable Protestant works were those by Thomas Becon and William Perkins (English Calvinists). Juan Polanco and Robert Bellarmine authored two of the finest and popular Roman Catholic tracts. Scores of other works were written but many who have studied this literature agree that *The Rule and Exercises of Holy Dying* by Jeremy Taylor (an Anglican) stands as the tradition's preeminent work.

Taylor artfully draws upon Christian and classical sources, placing considerable emphasis upon the need to prepare for death throughout life. One must make a lifelong effort to grow in patience (the ability to endure suffering steadfastly) and in faith (which would allow one to trust in God's love and mercy). To endure the pain and loss that comes with death, one must have learned how to endure life's smaller tragedies. To trust in God to preserve oneself through death into eternal life, one must have built up a strong attachment to God throughout life. Thus Taylor had a profound sense of the importance of habituation. One develops habits of patience, faithfulness, and hope so that one can remain patient, faithful, and hopeful in the agony of death. To promote this sort of growth, Taylor offers a sophisticated combination of meditations and concrete practices. His meditations are reminiscent of the approach to contemplation developed by Ignatius of Loyola (16th-century Roman Catholic); they speak to both reason and emotion while drawing deeply upon the use of imagination.

Taylor was an advocate of *momento mori*, or remembering death. This practice cultivated awareness that death could come at any time and entailed evaluating life choices according to whether they furthered or hindered progress toward spiritual growth and the ability to die well. Another key practice for Taylor was attending to the dying. Being present at the deathbed served the dying by offering them vital support, but also provided caregivers with an excellent means of preparing for their own death. This practice served as a form of momento mori and offered the opportunity to learn to die well by imitating the graceful death of friends and family.

Taylor's work was the last great book in this genre. No subsequent author equaled Taylor's artful rendering of the tradition or his masterful use of both classical and Christian sources on dying well. Taylor's work and some tracts that preceded his remained popular for generations until interest in the genre declined in the 19th century.

Christopher P. Vogt

See also Christian Beliefs and Traditions; Good Death; Spirituality; Symbols of Death and *Memento Mori*

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Assassination

Assassination is an ambiguous concept when used to describe events or when it is employed in general analyses. Assassination is selective killing; it also refers to the intentional killing of a public figure. These two views of assassination share the element of killing and are similar to the extent that the expressions "a leader" and "a public figure" refer to similar types of people. But they are also different from each other. Notice that according to the second definition, but not the first, assassination is a killing accomplished treacherously; this introduces into the second definition a dimension that is not present in the first one, namely the evaluative dimension. Unlike murdering, the notion of killing is purely descriptive. An act of killing can be evaluated as a morally or legally permissible or even an obligatory act, under certain circumstances of self-defense and necessity, but can also be evaluated as a morally impermissible or even abhorrent act, under circumstances of wicked aggression. The adverb *treacherously* is on a par with murdering rather than killing. To act treacherously is to act in a wrongful way. It is never justifiable. Recall Dante's attitude toward treachery in the Inferno part of his *Divine Comedy.* The circle of treachery is the ninth and final circle of hell. In its innermost zone and within Lucifer's mouths were Brutus and Cassius, eternally suffering for their assassination of Julius Caesar.

Consequently, a deep distinction emerges between a definition of assassination as a selective killing of a leader and a definition of it in terms of what is accomplished treacherously. Whereas the former definition leaves open questions of the justifiability of acts described as assassination, the latter definition leaves no room for any question of justifiability, since an act described as assassination involves treachery, which is always wrong. When the former definition is used, moral issues can and often should be considered. When the latter definition is used, it is pointless to raise such issues. A moral consideration has already been made and a negative evaluation reached. As a result of that deep difference between various definitions of assassination, we have an induced difference between discussions that employ, whether explicitly or between the lines, different definitions of the term.

The important distinction between descriptive and evaluative definitions of assassination is often blurred, when evaluative terms appear in seemingly simple conjunction with descriptive ones. For example, *assassination* is to destroy unexpectedly and treacherously a specific human target. A depiction of an act as performed unexpectedly is purely descriptive, even though it involves expectations, which are possibly subjective. However, a depiction of an act as performed treacherously involves both a description and an evaluation. Similarly, assassination represents a deliberate action that involves extralegal killing that is based on political ideologies. Assuming that an act can be extralegal and morally justified, the question is left open whether a certain act of assassination was morally justified or not, but the normative question of its legal nature has been closed by definition.

Given such a variety of definitions of the notion of assassination, preference must be given to one definition, or one family of similar definitions, in order to discuss assassination by giving examples of such acts, searching their meanings, and evaluating their justification. It has been demonstrated that there is a reason to prefer usage of terms that enables us to draw a distinction between a description of an act, activity, or event and its evaluation from a certain normative point of view, thus making the nature of the evaluation transparent. When descriptive terms are used, the mode of evaluation has to be introduced in a way that enables seeing the grounds of it. If evaluative terms such as *treacherously* are used, the grounds for portraying a certain act or policy as wrong are left unstated and remain unclear. Hence, in the sequel, assassination is going to be understood in a broad sense that leaves open for further discussion issues of moral, ethical, religious, or legal justification.

The difference between definitions of assassination that include a conveyed evaluative element and those that do not is not the only difference one encounters in the usage of the term and in its suggested definitions. Here is a list of features that appear in usage and analysis, some of which are necessary conditions for the occurrence of an act described as an assassination and some of which are not:

1. Killing a person
2. Killing a political leader
3. Killing a noncombatant

4. Doing it selectively
5. Doing it intentionally
6. Doing it in a premeditated manner
7. Doing it for political or religious purposes
8. Doing it unexpectedly
9. Doing it by a person not in uniform
10. Doing it in a secret and clandestine manner
11. Doing it treacherously

Given the background of the previous discussion, number 11 will not be included in the definition, thus leaving the question open whether an act of assassination under consideration is of a treacherous nature or not.

Some of the other 10 suggested definitional elements of assassination are features of common instances of what is called an assassination rather than necessary ingredients of the concept of assassination. For example, because an instance of an expected assassination can be imagined, element 8 of the list should not be an ingredient of an adequate definition. For similar reasons, ingredients 3 (an assassination of a head of state can take place whether or not the person is commander in chief, of a military rank, or in military uniform), 9, and 10 can be discarded as well.

Element 1 is indeed a necessary ingredient of the definition. Element 2 is problematic, as the term *assassination* has been used for describing acts of killing people who did not play any political role of leadership at the time of the killing. Paul Klebnikov wrote a book about corruption among Russian so-called oligarchs. Although he held no political position, whether formal or societal, his killing was later protested as an assassination. On the background of such examples, it is proposed that element 2, "killing a political leader," be replaced by the broader "killing a person of prominence," that could be political but not necessarily so. Element 7, "doing it for political or religious purposes," does not presuppose that the person killed is a political leader. Prominence is sufficient for rendering an act of killing, an act that can be intended and understood as done for political or religious purposes. This leaves elements 1, 2 (modified), 4, 5, and 7. Element 6 has been deleted as it can be included in element 7; what is done for political or religious purpose is necessarily premeditated, in a sense. Element 7 includes not only political reasons but also religious ones, as suggested by the Canadian Forces manual on the Law of Armed Conflict.

Thus, the following working definition of the term *assassination* is proposed for the present purposes: An assassination is an act of killing a prominent person, selectively, intentionally, and for political or religious purposes. This definition leaves open all questions of justification. An act of killing a prominent person, selectively, intentionally, and for political or religious purposes can and should be evaluated from any relevant point of view, be it moral, ethical, legal, or denominational. Notice that some of these points of view may vary in time. For example, the legal point of view of the United States, before the related Executive Order of President Ford, which banned assassination performed on the behalf of the U.S. government, later formulated in Executive Order 12333, is different from the present legal point of view of the U.S. government, assuming it has not been changed.

Examples of Assassination

Greece

King Philip II of Macedon conquered Greece, except for Sparta, in 338 B.C.E. and was about to fight Persia. During a wedding ceremony of his daughter Cleopatra to the King of Epirus in 336 B.C.E., he was killed by Pausanias, one of his bodyguards. According to some historians, it was an assassination in which his wife Olympias was involved. His son was Alexander the Great.

Rome

After successful battles, extended from Italy to Spain, Greece, and Egypt, Julius Caesar became, in 44 B.C.E., a self-declared dictator for life. Numerous Roman senators turned against him and conspired to assassinate him. When he came to a Senate meeting on the Ides of March 44, some senators, including Servilius Casca, Cassius, and Decimus Brutus, stabbed him to death. One result of the assassination was a series of civil wars.

Hellenistic Egypt

Hypatia, daughter of the philosopher and mathematician Theon of Alexandria, was the first

woman to be head of a philosophical school and to be known to have broad mathematical knowledge. Her special personality and her friendship with the Roman prefect Orestes served followers of the Christian Patriarch (later St.) Cyril as grounds for depicting her as responsible for the political rivalry between patriarch and prefect, Church and State. In 415 C.E., a Christian mob, possibly of Nitrian monks, assassinated Hypatia.

Medieval England

King Henry II appointed to the most influential position of chancellor his friend of "one heart and one mind," Thomas Becket. After Archbishop Theobald died in 1161, the king thought Thomas would help him reform the church. In 1162 Thomas was ordained priest and a day later consecrated bishop. However, as the archbishop of Canterbury, Thomas's first loyalty was to the church. In a series of events he was in conflict with the king. In 1170 four knights assassinated him in the cathedral. Two years later he was canonized.

The Netherlands

William I, Prince of Orange ("The Silent"), was governor of Holland under Philip II, King of Spain's occupation of the Netherlands. Later, he led a Dutch revolt against Spain, which led to the Eighty Years War between the two, which in turn led to the 1648 independence of the Netherlands. He was assassinated by a Catholic French supporter of the king of Spain in 1584. The Dutch national anthem, flag, and coat of arms are directly related to the "father of the fatherlands."

Russia

Emperor Paul I, son of Emperor Peter III and Catherine ("The Great"), formed the Second League of Armed Neutrality with Prussia, Denmark, and Sweden but was rigidly conservative in internal affairs. He was assassinated in 1801 by dismissed officers and other officials led by Levine August, Count of Bennigsen, and a general in the service of the emperor. The assassins declared emperor his son, Alexander I (eventually, "The Blessed").

The United States

Abraham Lincoln, the 16th president of the United States, defeated the Confederate States of America in the Civil War. His executive orders, "Emancipation Proclamation," were significant steps toward ending slavery in the United States. On that background, a Confederate agent assassinated Lincoln on April 15, 1865, while coconspirators failed to assassinate Vice President Andrew Johnson and Secretary of State William H. Seward.

World War I

Archduke Franz Ferdinand, heir apparent to the throne of Austria-Hungary, was assassinated in Sarajevo, on June 28, 1914, by a Serbian group interested in the independence of Serbia. Within a few weeks, a war erupted between Austria-Hungary and Germany, on the one hand, and Serbia, Russia, France, and Great Britain, on the other hand, which lasted more than 4 years. Many other states joined the war, among which were the United States and Italy. The number of military deaths is estimated between 9 and 10 million, that of civilians between 8 and 9 million.

India

Mohandas Karamachand ("Mahatma") Gandhi was born in India, educated in England, and experienced discrimination during a long stay in South Africa, where he developed his political position of nonviolent struggle. Upon returning to India, he led the struggle against the United Kingdom, for the independence of India. His insistence on nonviolent methods and his religious tolerance enraged some Hindu fundamentalists, who made five attempts to assassinate Gandhi. On January 30, 1948, he was assassinated, in Delhi, on his way to a prayer meeting.

On October 31, 1984, India's prime minister, Indira Gandhi, was assassinated by a Sikh bodyguard, on the background of a conflict related to Sikh temples. Her son, Ragiv Gandhi, immediately followed her as prime minister. On May 21, 1991, after resigning from office, he was assassinated by a female suicide bomber, a member of a Tamil extremist organization.

Israel

After the Oslo accords were signed by the Government of Israel and the Palestinian Authority, which involved prospects of Israel's withdrawal from belligerently occupied Palestinian territories, Israeli Prime Minister Yitzhak Rabin was assassinated, on November 4, 1995, by an extremist, nationalist-religious Jew. The assassination was followed by changes in the ruling party, government, and policies.

Meaning and Justification

Every case of assassination involves, by its nature, causing the death of a prominent person for political or religious purposes. However, the full meaning of an assassination has an additional element: An assassination can be instrumental or symbolic. In the former case, the death of the assassinated person is a necessary condition for achieving the purpose of the act. The assassination of Julius Caesar is an example as are most of the previously mentioned cases. In the latter case, an interpretation of the assassination is meant to be understood by members of the groups directly related to the political or religious purpose of the act. The assassination of the Archduke of Austria-Hungary, for example, was not a necessary precondition of the independence of Serbia, but it stood for the struggle of some Serbians for their political independence.

Moral evaluation of an act of assassination depends on the full intended meaning of the act. The simpler cases are the extreme ones. On the one hand, if it can be certainly assumed that the assassination will radically change for the better a horrendous state, such as an ongoing genocide, by removing from power, in the only way possible, a person who is responsible for the atrocities, then assassination is permissible. The case of Hitler during World War II is a prime example. On the other hand, assassination meant for symbolic purposes is always morally wrong, because it involves treating a person as merely a means to an end.

Symbolic acts of assassination are never necessary and always have better alternatives.

U.S. Executive Order 12333, which forbids acts of assassination of or on the behalf of the United States, marks a presumption that such acts are usually morally wrong. Reasons for such a stance with respect to intermediate cases have involved a variety of considerations. Because heads of states are often not members of the armed forces, the Principle of Distinction between combatant and noncombatants has been invoked. This is not a compelling argument, as heads of states are often directly involved in crucial warfare decision-making processes. Some analysts argue that persons with whom peace will eventually be negotiated and reached should therefore not be assassinated. When assassination is meant to terrorize people, the arguments against terrorism convincingly apply against it. Usually, assassinations cannot be justified on grounds of necessity and therefore are understood to be symbolic in nature and therefore morally wrong.

Asa Kasher

See also Atrocities; Death, Humanistic Perspectives; Hate Crimes and Death Threats; Homicide; Legalities of Death

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Assisted Suicide

The 20th century, with its rapid progress in medical science, has fundamentally changed the nature of the dying process in much of the Western world. Modern advances in medicine and life-sustaining technology have resulted in a dramatic increase in life expectancy and quality of life. However, these changes have also given rise to the concern that the dying process may be unnecessarily lengthened, leading to prolonged suffering and loss of dignity for many terminally ill individuals. This concern has increased public interest in the legalization of a range of end-of-life practices, including assisted suicide.

Terminology

Assisted suicide is defined as a situation in which a person with an incurable, terminal illness requests the help of others in ending his or her life. The person providing assistance typically supplies the terminally ill patient with the means or information necessary to bring about death. When such assistance is provided by a physician, the practice is referred to as physician-assisted suicide (PAS). Assisted suicide and PAS are often confused with another end-of-life practice, euthanasia. Specifically, euthanasia refers to the act of taking another person's life with the aim of alleviating suffering. Assisted suicide and euthanasia are distinctly different practices, because PAS allows patients to be the active agents in controlling the circumstances of their death, whereas in euthanasia, the person who performs the actions leading to death is someone other than the patient. Another practical distinction is that PAS usually involves a physician's prescription of a lethal dose of medication, whereas euthanasia often involves the administration of a lethal injection.

Arguments About Assisted Suicide

The distinction between assisted suicide and euthanasia is significant, given the heated nature of the debate surrounding legalization of assisted suicide. A number of arguments have been voiced in the public discussion surrounding this issue. Proponents of legalization argue that individuals have a fundamental right to personal autonomy and that assisted suicide allows terminally ill patients to maintain dignity and control at the end of life. It is further suggested that PAS can address terminally ill patients' concerns with maintaining autonomy and quality of life, whereas pain control interventions and palliative care may be ineffective in resolving these concerns. In addition, proponents argue that assisted suicide already exists as a hidden practice, so legalization can ensure that appropriate monitoring and safeguards are enforced. Finally, PAS advocates suggest that practices that relieve suffering and respect patients' autonomy are consistent with the physician's role and conform to current ethical and medical principles.

Opponents of legalization, on the other hand, often cite the sanctity of human life and the moral unacceptability of suicide as arguments against assisted suicide. Providing assistance in a patient's suicide is explicitly prohibited by the Hippocratic oath, and some view PAS as inconsistent with the physician's obligation to preserve life. Apart from such moral and ethical objections, opponents often argue that adequate palliative care and pain management can eliminate patients' need to resort to assisted suicide. They also voice a concern that the legalization of PAS may stifle progress in the hospice movement and thwart current developments in end-of-life care. Some fear that the legalization of PAS may put pressure on patients to choose assisted suicide in order to avoid becoming a burden to family and caregivers. Finally, opponents point to the danger of a slippery slope—the concern that, over time, PAS may be applied to those who are not terminally ill, as well as those who are physically disabled or have a mental illness.

The Practice of Assisted Suicide

Given the heated nature of the debate surrounding the legalization of PAS, it is no wonder that this practice is a legal option in only a handful of countries. At the time of this writing, only the Netherlands, Belgium, Switzerland, and the U.S. state of Oregon have implemented legal regulations that explicitly permit PAS. Some important differences exist in the way PAS is practiced in

each of these areas of the world, so a discussion of cross-national variations is warranted.

The Netherlands has a long history of legal tolerance toward PAS and euthanasia, and both practices were eventually legalized in 2001 with a law passed by the Dutch Parliament. Under this statute, physicians can perform either euthanasia or PAS in cases where a patient has made repeated, voluntary, and well-considered requests and perceives his or her suffering as unacceptable. The physician must be convinced that the patient's situation is desperate, although a terminal medical condition is not explicitly required. Furthermore, the attending physician needs to consult with a colleague as well as document and report all actions taken. When parental approval is provided, the Dutch law also permits PAS for patients ages 12 to 18 years old.

A year after the Netherlands law was passed, Belgium followed suit by legalizing euthanasia. The Belgium law does not explicitly mention PAS because of cultural prohibitions against suicide; however, PAS is currently performed and considered an act of euthanasia in this country. The Belgium law is similar to Dutch practices in that it requires a patient's repeated, voluntary, and well-considered request for euthanasia and the presence of intractable suffering. A consultation with a second medical professional and the careful documentation and reporting of all practices are required as well. However, this law also includes more stringent criteria by explicitly requiring that the patient be 18 or older and suffer from an incurable medical condition. Thus, some similarities and differences exist in the way PAS and euthanasia are defined and practiced in Belgium and the Netherlands.

In contrast to the statutes in Belgium and the Netherlands, a unique legal situation exists in Switzerland, where the penal code implicitly authorizes assisted suicide (either by a physician or a lay person), provided that aid-in-dying is not motivated by a desire for personal gains. Although the Swiss penal code opens a possibility for the decriminalization of assisted suicide, it explicitly prohibits euthanasia as a form of murder.

Although international issues surrounding PAS are noteworthy, the legalization of PAS in the state of Oregon is of particular significance in the United States. In 1994, a state referendum supported the legalization of PAS in Oregon, when voters approved a measure to pass Oregon's Death With Dignity Act (DWDA). The DWDA was eventually enacted in 1997, making Oregon the first state to pass a law allowing PAS in the United States. Under this act, a competent, terminally ill, adult resident of Oregon may request a physician's assistance in dying provided that certain regulations are met.

A number of requirements are built into Oregon's DWDA as a safeguard against abuse. In order to make use of the statute, a patient must first make two verbal and one written request for aid-in-dying, separated by at least 15 days. Next, the patient's terminal diagnosis and decision-making capacity need to be confirmed by the attending physician and a consulting colleague, with a referral to a psychologist or psychiatrist in cases where the patient's judgment may be impaired because of a mental health condition. Finally, the patient has to be informed of alternative end-of-life options, and the prescribing physician must suggest (but not require) that the patient inform significant others of his or her end-of-life decisions. Provided that these requirements are met, the attending physician may prescribe a lethal dose of medication, after which a report is filed with the Department of Human Services. Such regulations are designed specifically to protect patients' rights while respecting their personal dignity and autonomy.

The legalization of PAS in Oregon, the Netherlands, Switzerland, and Belgium has spurred a vibrant line of research examining the incidence and characteristics of end-of-life practices in these countries. The reporting practices in the Netherlands and Oregon, in particular, have generated an expanding body of data regarding incidence rates, demographic characteristics, and reasons for patients' requests for PAS. Available data suggest that only a small percentage of patients make use of PAS. Specifically, in 2005, 0.1% of deaths in the Netherlands and 0.12% of deaths in Oregon were the result of PAS. The most common reasons for requesting PAS in Oregon included concerns related to the loss of autonomy, dignity, or personal control, whereas fear of uncontrollable physical pain was a less important factor in patients' desire for assisted suicide. Such research findings enhance the humanistic perspective of this social issue.

In conclusion, assisted suicide and PAS have increasingly become a center of scholarly and public discussion. Informed participation in the assisted suicide debate requires knowledge of terminology and familiarity with the arguments regarding the legalization of this practice. Legalization has become an important aspect of the assisted suicide debate, and a number of countries (i.e., the Netherlands, Belgium, Switzerland, and the U.S. state of Oregon) have implemented statutes that permit PAS under certain conditions. One important outcome of the legal status of PAS in these countries is the proliferation of research on the practice of assisted suicide with the potential of furthering current understanding of end-of-life issues.

James L. Werth Jr., Elena Yakunina, and Jessica M. Richmond

See also End-of-Life Decision Making; Euthanasia; Good Death; Legalities of Death; Quality of **Life; Suicide; Terminal Illness and Imminent Death**

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Atheism and Death

Atheism is the disbelief in the existence of a deity. Although atheism is often associated with agnosticism, it has its own distinct meaning. Whereas agnostics believe that it cannot be known whether there is a god, atheists explicitly reject the existence of such a being. This rejection especially manifests itself in periods of secularization in which the immanent world becomes evermore important at the expense of the metaphysical constellation of god, world, and soul. This does not mean that representations of a transcendent world, such as god, heaven, and afterlife, no longer exist—it means that people in a secularized society may reject these notions as part of their lived reality. Because many people live in a secularized society, atheism is relevant for understanding death from a nonreligious point of view.

Atheism itself gives no meaning to death—it only rejects transcendent interpretations of death. From an atheistic perspective, meaning of death results just from an immanent analysis based upon the profane and worldly interpretation of reality. As a consequence, atheistic meanings of death are defined both by immanent meaning and by the disbelief in a deity. Although immanent meanings of death can go together with a personal belief in god, this is not the case in atheism. In the following, immanent meanings of death are explored by first sketching the main sources for immanent meaning. From there, three immanent meanings of death are presented and future immanent meanings of death are briefly explored.

Immanent Meanings of Death

The main sources for immanent meanings of death are nature and the human being. Nature-centered meanings have roots in the ancient thought of materialism—the doctrine that reality has objective existence that consists of material

particles—and have been further developed in the movement of naturalism from the early Renaissance onward. Generally speaking, these immanent meanings represent the idea that nature provides a strict physical understanding of reality, including the reality of death. Human-centered meanings have roots in the ancient thought of immanent idealism—the doctrine that human ideas make up the reality as we know it—and have been further developed in the Renaissance movement of humanism. Generally speaking, these immanent meanings put humankind and its capacity to give meaning to reality in the center of the universe.

The lines of thought from materialism to naturalism and from immanent idealism to humanism present different meanings of death. Natural-centered meanings of death tend to reduce persons to their complex material bodies. In such a perspective, death does not mean the end of one's existence—persons continue to exist as corpses for a while after they die, whereupon the body recycles into other forms of nature through physical decay. Although this gives meaning to a bodily death, it does not do so for death as a psychological annihilation. Human-centered meanings of death, on the other hand, tend to reduce living persons to their potential for self-realization. For example, many humanists believe that people continue to exist in the contribution they made to create a better world. As such, individual pleasures, ideas, and achievements may transcend death. Although this perspective provides meaning, it regards life rather than death. As a consequence, both nature- and human-centered meanings of death remain limited in their analysis. However, there are exceptions to this limitation. Three of them will be explored in the next sections.

Epicurean Perspective

A first thoroughly elaborated immanent meaning of death is presented by Epicurus (341–270 B.C.E.). Although Epicurus believes in the gods, he sees them as entirely unconcerned about human beings. Epicurus's analysis on death is built on a strict materialism in which the human being has no metaphysical or transcendent meaning. He believes that objects exist only when they can be perceived or imagined as material objects. As a consequence, reality is exactly as it appears to our senses, assuming that our senses function accurately. Everything not material is simply the absence of reality and thus nonexistent.

According to Epicurus, there is no need to fear death. Moreover, he argues that death is not a misfortune for the one who dies. He presents an impressive proof for the irrationality of the misfortune of death. He claims that all good and bad consists in sense-experience. Because death is the privation of sense-experience, it does not exist. As a consequence, death, the most terrifying thing, cannot affect the living. We will never meet death, for when we live, death is not present, and when death is present, we do not live. Because we can never perceive death, death is of no concern to us and there is no reason to fear it—death means nothing to us.

The Epicurean perspective on death may not satisfy those who experience the shock of having to die. However, the therapeutic purpose of Epicurus's argument should not be underestimated. For Epicurus, knowledge is not an end in itself but a remedy for mental disquietude. Through meditating upon his line of argument, one's fear for death may be transformed into equanimity. The strength of this argument depends entirely upon the premise that all knowledge lies in sensation. When death cannot be perceived, its impact upon our emotional life must be illusionary. Thus, by excluding metaphysics, Epicurus nullifies death. Hence, a first immanent meaning of death is the exclusion of death from our experiential world.

Heidegger's Position

A second thoroughly elaborated immanent meaning of death is presented by Heidegger (1889–1976). Heidegger's position is neither theistic nor atheistic. He breaks with metaphysics, which for him is the traditional way of thinking in which the question of being is ignored. Instead, Heidegger wants to do justice to the immanent reality of being as such. He does so by exploring what it means for the human being to be. Metaphysics cannot provide the answer, for Heidegger rejects any metaphysical presupposition concerning the essence of humans. However, because life cannot generate its own meaning, it still has to relate to something outside of life. Heidegger finds this immanent outside in the finitude of one's own being.

According to Heidegger, understanding the structure of being is achieved through understanding the meaning of nonbeing, which, for the human being, is death. However, one cannot understand one's own death from experience, for death by definition lies outside of experience. As a consequence, death can only be understood as a future event, which is the possibility of one's own death: Death is the possibility of the absolute impossibility of being-there. Since this possibility is one's own most, nonrelational, and unrivalled possibility, it is distinctively impending. This means that one's being is structured by one's outlook on death—the human being is a being toward death.

By focusing on people as *finite* beings and on the *influence* death has on life, Heidegger overcomes the problems of both humanism, which focuses on human beings as potential beings, and naturalism, which places death outside of experience. Death can now be explored as a real phenomenon. It is the life-structuring event that guides all of our choices and projects. As such, it is the background against which life is configured. Only when people think of their relationship to death as manifest in each aspect of life can they be genuinely aware of what it means to live authentically—that is, to live as a human, and thus finite, being. Hence, a second immanent meaning of death is that it structures life within our experiential world.

Sartre's Philosophy

A third thoroughly elaborated immanent meaning of death is presented by Sartre (1905–1980). Sartre characterizes his philosophy as an atheistic humanism. He profoundly disagrees with Heidegger's analysis of death and claims that death cannot be considered an outside force that provides immanent meaning to life. Death cannot confer meaning, because meaning comes only from subjectivity. Any meaning of death is thus necessarily human. Death, as such, renders life useless and senseless for it deprives life of all meaning. Human problems remain unsolved and the meaning of these problems remains undetermined. As a consequence, awareness of finitude cannot provide an authentic mode of being.

According to Sartre, the meaninglessness of death prevents death from being a possibility. Instead, death is the end of all possibilities. This claim has important implications for the understanding of what it means to be a human being. When death is the nullification of all one's projects, it escapes one by principle. One cannot discover one's own death, nor wait for it, nor take an attitude toward it. Death reveals itself as indiscoverable for it disarms all expectations. As such, nothing can happen to death from the "inside," as it is completely closed and impenetrable. As a consequence, death does not belong to the ontological structure of the self. Instead, death is the victory of what lies outside the self—for the self, death is an absurdity.

The triumph of the outside over oneself, however, does not imply that one cannot freely give meaning to life. The absurdity of death shows us that one is not constrained by death. Moreover, death reveals our freedom. Although one is not free to die, one is a free mortal. Death thus reveals that one's freedom remains total and infinite. This revelation of infinite freedom suggests that the human condition can be transcended. That is to say, through one's infinite freedom one may overcome situations in which one experiences one's mortal status. Hence, a third immanent meaning of death is that it reveals an infinite freedom toward our experiential world.

Overcoming Death

Future elaborations of immanent meanings of death may result from developments in transhumanism. Transhumanism aims for the enhancement of all limitations of the human condition, including death. Most transhumanists are atheists with a materialistic perspective on life. They rely heavily on the promises of science and technology. For example, by understanding aging as a pure biological process on the level of molecules and cells, transhumanists suppose that insight in these processes may lead to enormous life extension. Aging can already be slowed down for small animals, and some scientists claim that the process of aging may be reversed in the future. Because from a transhumanist perspective death is to be postponed, and in the future even to be overcome, it is to be expected that these developments will have an effect upon the meaning of death.

The postponement and overcoming of death is less futuristic than it may seem. For example, in medical care the hope and belief in technology is

often the last resort for saving lives. When both patients and doctors are unable to come to terms with death, treatment may be pushed extremely far at the end of life. Transhumanism claims that if it becomes possible to overcome death, many people would opt for it. A first step toward immortality has already been made: With the help of cryonic preservation, cardiac dead people can "wait" for new technologies that may cure their life-threatening illnesses. This may lead to new immanent meanings of death in which the materialist doctrine of continued existence after death goes along with the humanistic promise of ultimate self-realization. This may be threatening for most religious perspectives on death; for atheists it just reflects the justified human aspiration to live and not to die.

Eric J. Ettema

See also Cryonics; Death, Philosophical Perspectives; Immortality

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Atrocities

An atrocity is morally wrong behavior that is so horrendous that it reveals a brazen disregard for the humanity of the victims. The aim of an atrocity is not just to harm the victims, but to desecrate them. Not every moral wrong, then, counts as an atrocity. The typical lie or act of shoplifting is hardly an atrocity. Not even murder need be about desecrating the victim. The list of atrocities that human beings have committed throughout history is disconcertingly long. During the 1990s, the killing of hundreds of thousands of Tutsis occurred in Rwanda, where leaflets and posters were distributed by Hutus characterizing Tutsis as snakes and cockroaches. Symbolically, snakes and cockroaches are rivaled only by rats as creatures that are viscerally the antithesis of what it is to be a human being. In Rwanda, it was blacks desecrating blacks. In the Asian world, Asians have desecrated Asians, as with China and Japan. In the Muslim world, Muslims have desecrated one another. Saddam Hussein, for instance, treated Shi'ite Muslims in a way that calls to mind the Nazi treatment of Jews.

The atrocities of the Nazi era represent the most sophisticated and sustained desecration of people to have taken place in the 20th century. And while it is clear that the extermination of the Jews was the central aim of the Nazi regime, it is equally clear that an ineliminable part of that aim was also to kill the Jews in a most dehumanizing manner. From transporting Jews to concentration camps in trains that had no restroom facilities of any form to making them dig their own graves to the brutal ways that they were used in so-called medical experiments, the aim was to peel away the Jews' sense of humanity.

Strikingly, atrocities are often committed by individuals who regard themselves as decent individuals. For instance, the lynching of blacks by whites in the United States in the Old South was typically committed by whites who considered themselves to be God-fearing Christians. The aim of lynching was not merely to punish blacks, but to revel in an utter disregard for the black body. During times of war, it commonly happens that male soldiers who think that rape is reprehensible nonetheless rape women who are identified as being on the side of the enemy. Needless to say, rape is one of the most profound ways in which a body can be desecrated, where the aim is not at all about killing the victim.

Evil Behavior and a Sense of Community

How can psychologically healthy people who take themselves to be decent individuals collectively do the unthinkable to others? Two important considerations present themselves. First, a defining feature of human beings is that they are capable of symbolic representation. A symbolic representation can be ephemeral and of little social significance as with the white glove that was once identified with Michael Jackson. Symbolic representation can also be imbued with enormous meaning and thereby occasion visceral feelings, as has been the case with two pieces of wood whose formation constitutes a religious symbol, namely the cross. People, too, admit of symbolic representation. Owing to upbringing, even psychologically healthy individuals may reach adulthood with a wealth of visceral feelings that are positive toward some individuals and negative toward others. Most of us rarely act on our negative feelings alone.

The second part of the explanation for atrocities is that when a group of people act hostilely in concert with one another, the sense of moral responsibility that members of the group have is, from a psychological point of view, quite diffused. Indeed, it is surely true that no single person is responsible or blameworthy for all that happens. For example, what exactly has one done if one was part of a crowd of individuals who blocked the escape of an innocent person who was subsequently hanged or tortured by those pursing that person? Moreover, not only does a crowd diffuse blame but it also provides individuals with a considerable measure of anonymity. Finally, in this vein, there is the fact that interpersonal comparisons are an ineluctable aspect of our self-assessment. Even if the way in which everyone is behaving is clearly wrong, the fact that everyone is so behaving is easily enough countenanced as an excuse for behaving in that manner. This is because the ubiquity of the wrongful behavior as evidenced suggests that only someone of unusual strength of character could be expected to refrain from the wrongful behavior in question; and while it is certainly nice that a person has such strength of character, no one can be expected to be that strong. In a word, one of the rationalizations for their own moral behavior, which many find most potent, is the simple reality that everyone is behaving in that manner.

Putting these two explanations together, atrocities can be explained as follows: When a group of people have been demonized, then the members of the demonized group have been symbolically represented as a profound danger to the physical and moral well-being of the group of individuals who consider they represent a higher moral order. Hitler, for example, claimed to be doing the work of the Lord in his attempt to exterminate Jews. Typically, the members of a demonized group are characterized as subhuman in some way or morally beyond the pale; accordingly, commonplace human sympathies toward members of the demonized group for the enormous pain inflicted upon such individuals are considered inappropriate, even a sign of weakness. When a group of people has been demonized, then it does not take much more than a social spark to occasion atrocities on the part of the members of the group who consider they represent a higher moral order. A social spark means something like the following: (a) one or more members of the demonized group have acted inappropriately toward a member of the group with the supposed higher calling when the members were, for instance, already weary of one another; or (b) the members of the group with the supposed higher calling question the fidelity of a particular member of their group. The slightest infraction on the part of a member of the demonized group thus presents an opportunity for one whose group loyalty has been questioned to publically affirm his or her disdain for the demonized group, while simultaneously affirming her or his identity with those who claim to have a higher calling.

Of course, atrocities can also be orchestrated. Those in Rwanda and Nazi Germany most certainly were orchestrated, and the systematic dehumanization of the victims was par for the course. What is equally true, however, is that atrocities can occur rather like spontaneous combustion. Lynching in the United States was much more like that than not.

One might think that individuals who have been members of a demonized group would never commit against others the kinds of wrongs that were committed against them. Unfortunately, this is not the case. People who have been demonized seem to be more than capable of demonizing others. The desire for revenge can blind people to their own ignominious behavior, as was the case in

Rwanda with the Hutus against the Tutsis. What is more, egregiously immoral behavior can be adopted as a means of control even by those who have been the primary target of such behavior. Joël Michel reports that lynching had become such a cultural practice in isolated areas of Louisiana that there were occasions when blacks would lynch a black, and there were 12 occasions when blacks joined with whites in lynching a black. Of course, these numbers are utterly insignificant when compared to the thousands of blacks lynched by whites only. However, these numbers underscore in a most poignant way that when it comes to atrocities, people can do the unthinkable. As Mark Rigg has shown, the same poignancy arises with people of Jewish descent willingly serving in Hitler's army.

Human Malleability

Philip Zimbardo's classic work, "A Study of Prisoners and Guards in a Simulated Prison," supports the line of argument presented in the preceding section. Student volunteers were variously assigned the role of guard or prisoner. The stunning surprise was that the "guards" began to take their role so seriously that they started mistreating the "prisoners" rather harshly—so much so that the experiment had to be stopped. Here we have an elite group of students who, beyond all shadow of a doubt, know that all are students who are equally innocent of any wrongdoing. Yet, the simple truth is that it was impossible for the so-called guards to take their role seriously without in some way demonizing the so-called prisoners, with the result being that otherwise decent and highly intelligent individuals willfully harmed individuals whom they knew from the outset were equally innocent and intelligent and from similar social backgrounds. The Zimbardo experiment points to the malleability of human beings. Even in a context that was publicly defined as mere role playing, among people who were equal in all the relevant social respects, the so-called guards began to think of themselves as having a higher moral calling. In turn, they viewed the so-called prisoners as morally inferior and proceeded to treat them quite harshly.

The malleability of human beings is both one of their greatest strengths and greatest weaknesses. Its strength lies in the ability of human beings to adapt ever so successfully to environments that differ radically from what they have previously experienced all of their lives—to achieve what had heretofore seemed impossible, as when Erik Weihenmayer, a blind person, climbed Mt. Everest. The liability is that these same creative powers make it possible for human beings to accord great significance to otherwise inconsequential differences, as Zimbardo's prison experiment astonishingly revealed. Evolutionary biology makes it unmistakably clear that phenotypical differences between human beings that allow for group classifications are utterly inconsequential, in that differences in moral and intellectual powers cannot be attributed to these phenotypical differences. Yet, with ingenuity and uncanny persistence human beings continue to accord great significance to these differences. Even in the 3rd millennium, what is known as scientific racism and the concomitant claim of racial superiority continue to have a serious foothold in human thought. One might ask whether we should take the ubiquity of racism on the part of human beings, with all that this entails in terms of humanity being susceptible to committing atrocities, as an indication of the equality of human beings.

Human Psychology: Justice Versus Evil

In *Republic,* Plato claims that the truly just are those who would live justly though the entire world treated them unjustly. Unfortunately, this is an ideal that would seem to be at odds with our psychological and social reality. This is because psychologically healthy human beings are quintessential social creatures, and this reality plays itself out in fundamental respects. First of all, social approval plays a fundamental role in how we conceive of ourselves. From physical appearances to intellectual prowess, the sense of self is inextricably tied to the assessments that others make of us.

What is more, there is unavoidable truth that there is much that is meaningful in life that cannot be done without the support of a community. The paradigm examples in this regard are friendship and love. Nearly everyone agrees that life without at least one of these is lacking in richness. However, there are many other communal activities that add to the meaning and richness of life, such as team sports or card games or group singing.

In the vast majority of instances, then, being part of a group is far too central to leading a psychologically healthy and flourishing life as a human being for Plato's idea of a just person to have an unshakable hold upon human lives. To recognize this much is to have deep insight into how it can be that psychologically healthy human beings commit atrocities. Contrary to what Plato thought, in order to be the kind of person who would choose justice over fitting in with those who have been a deep source of affirmation, it takes a strength of character (which most people do not have) and a willingness (which most people do not have) to make enormous sacrifices. And while we rightly admire saints and heroes, it is equally clear that we do not think that anyone can be morally required so to behave on behalf of others (with perhaps the case of immediate family members aside).

Fitting in with others is a form of self-preservation. Atrocities, then, tap into the most basic and fundamental of human instincts, namely self-preservation. This is because being a part of an affirming group is also one of the most basic forms of self-preservation. This follows from the fact that human beings are quintessentially social creatures. There is no need to deny that the difference between human beings and other social animals, such as dolphins and chimpanzees, is but a matter of degree. We need only note that small differences in degree can make a monumental difference in kind. The addition of language makes a profound difference. This is because atrocities are tied not just to feelings of hostility but also to the capacity of human beings to give articulation to those feelings and thus to proffer a symbolic representation of those feelings for other members of the community to embrace, avow, and thus for human beings to use as a ceremonious way of affirming their unity while simultaneously reinforcing their conception of the other as unfit. What is more, the corollary to the capacity for the spoken word is the capacity for the written word, which transforms the dissemination of ideas. Owing to these differences between animals and human beings, we do not regard animals as being capable of committing atrocities or, in any case, as capable of being morally responsible for their behavior. So it is even when, for example, we deem it appropriate to kill an animal for having mauled a human being to death.

Perhaps Plato may have the last word after all. He held that individuals could not be truly just unless, from the outset of their lives, they were entirely raised in just the right way. In the same way that defective buildings cannot be expected to survive major storms, people whose character formation is flawed cannot be expected to survive major moral storms. If this is right, then the explanation for why atrocities have been a painfully enduring part of human history is not so much that human beings have not had noble ideals. Rather, it is that in most societies it is profoundly rare that children have been raised with the kind of moral foundations that make it possible for them, once they reach adulthood, to weather major moral crises. In the absence of such a foundation, psychologically healthy people can do the unthinkable, namely be utterly indifferent to the humanity of another. In a word, Plato would say that atrocities exploit the fundamental moral imperfections of our upbringing.

Laurence Thomas

See also Death Squads; Disasters, Man-Made; Genocide; Holocaust; Lynching and Vigilante Justice; Massacres

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Australian Aboriginal Beliefs and Traditions

The interest in Australian Aboriginal beliefs and traditions increased in the late 19th and early 20th centuries as European scholars tried to understand the origin and evolution not only of the human species but also of its religion and culture. Australian Aborigines were believed to be in the early stages of this development, representing the dawn of humankind, according to the models of cultural evolution at the time. In remote Australia, so-called wild Aborigines, almost untouched by European civilization, would thus enable scholars to gain a better understanding of how their forebears must have lived tens of thousands of years ago. The term *Aborigines* denotes this understanding of a people from the origin (*ab origine*), exemplary for the beginnings or early manifestations of social institutions and cultural forms.

Australian Aborigines were of great importance for social theorizing: Émile Durkheim's work on the elementary forms of religion and Sigmund Freud's idea of the primordial band, for example, were based on contemporary knowledge about indigenous Australians. To this body of literature the books published from 1899 onward by Baldwin Spencer and Frank Gillen made a major contribution. Because Gillen, a postmaster, had become acquainted with Aborigines in Central Australia, he and Spencer, a Melbourne professor, managed to document their traditions and beliefs in great detail. Spencer and Gillen did so on the basis of first-hand information and even direct observation of a totemic ceremony that would become crucial evidence for Durkheim's theory on social cohesion. Bronislaw Malinowski also grappled with Australian materials on the Aboriginal family. And Alfred Radcliffe-Brown documented and analyzed the intricacies of Aboriginal social organization and the variety of systems of kinship in Australia.

Across Australia an estimated 500 distinct indigenous languages were spoken. With also considerable variation in their habitat, Aboriginal groups differed in lifestyle and cultural practices enough for the continent to encompass many indigenous cultures. Although the perspective is complicated because a great many Aborigines are multilingual, almost all Aborigines share adherence to the general outline of a cosmology.

The Dreaming

The central concept in understanding Aboriginal cosmology is the Dreaming, the mythological, formative era during which the enduring shape of the earth was created, patterns of living were established, and laws for human behavior were set down. Spencer and Gillen introduced the term "the Dream time" for the Aboriginal cosmology. It was their translation of the word *alcheringa* from the Aranda (now: Arrente) in Central Australia. Although this translation is somewhat misleading, Aborigines have adopted it in speaking in English about their worldview. Most commonly used by Aborigines today are the terms *The Dreaming* and *Dreaming*. Another expression that has currency is *The Law*.

Dreamtime, the Dreaming, and related terms refer to the creation time. According to Aboriginal creation stories, Ancestral Beings reshaped the world in a long distant past. Thus, in contrast to the creation myths of world religions, this was not a creation out of nothing. The world already existed as an inert, amorphous mass of clay or, covered by water, in fluid condition. The powers of the Dreaming emerged from this mass, came to the surface, took human-like shapes, and wandered over the earth. In the process they had adventures, recounted in the creation stories, that were events that molded the landscape, and created nature and culture. Ancestral Beings transformed into animals and other creatures, vegetation, natural features such as rocks and creeks and waterholes, natural forces such as thunder and rain, and visible elements and formations in the sky. The Ancestral Beings gave Aborigines a blueprint for their way of life. According to the

creation stories, the Ancestral Beings also installed the major religious ceremonies.

Some of the narrated events of the Dreaming are reenacted in those ceremonies. Although the Dreaming refers to the long distant past of the creation time, for Aborigines the Dreaming is omnipresent in space and time—past, present, and future. Generally speaking, Aborigines attribute all acts of creativity to the Ancestral Beings of the Dreaming. So, in principle, there is no difference between patterns or designs found in nature and those made by Aborigines in the context of their ceremonial life. Both kinds of design may be conceived of as traces of the Dreaming, containing spiritual power. Their world is one of meaningful signs, and every sign is a statement of their being in the world.

The Dreaming thus continues to have relevance for the present as well as for the future through the Ancestral Beings that were present and active at the beginning of life and continue to exist and exert their influence. They are incorporated into the social system of clans and kinship, and their interrelationships resemble those between social groupings. Following Kenneth Maddock, a distinction between these Ancestral Beings can be made between so-called transcendental and totemic powers. The difference between both types of power corresponds to differences in the magnitude of their creative acts. Furthermore, the former transcends the specific social divisions connected to clans or particular kinship relations. The latter are associated with certain social groups, such as clans, to the exclusion of others.

Mythological Beliefs

Throughout Australia, a great diversity in mythological beliefs can be discerned. An example may be seen in geographical differences in the perception of transcendental powers. In the southern and eastern parts of Australia, an "All-Father" figure is said to have had decisive influence in shaping the earth, whereas in northern Australia, such formative power is ascribed to an "All-Mother" figure. Respective examples are Ngurunderi from the Lower River Murray area and Murtankala from Bathurst and Melville Islands. The majority of religious myths describe the wanderings and activities of various creative beings. However, in view of the great variation in the natural environment, it is not unsurprising that there exists an equal variety in explanatory myths. Moreover, even within clans and kinship groups, no single version is necessarily accepted as the only correct one. Frequently, the ancestral connections referred to reflect the protagonists' representations of social relations and subsequent relations to the land. Ideologically, Aborigines state they belong to the land rather than that the land belongs to them. Claims to the relevant ancestral connections have to be rooted in the authority of the Dreamtime, a privilege of the initiated, but it is still more of an achievement than a given since new aspects of Dreamtime stories, supposed to have always been there, can be revealed in a dream, a vision, or a newly made design. Whether such revelations, embodying the hidden dynamics of the Dreamtime, catch on and find acceptance or not often depends on the political state of affairs. Interestingly, introduced species, Jesus, cars, and planes, among other things, have been appropriated and incorporated in Aboriginal totemic systems.

How Death Came Into the World

The moon figures prominently in various Australian Aboriginal myths about the origin of death. In these myths, an ancestral being dies and another being, the moon, offers to revive the first dead ever. The offer is refused. Hence, death has come to the world. The myth of the cultural hero Purukupali and his brother Tapara from Bathurst and Melville Islands, northern Australia, is a case in point.

Toward the end of the creation period Purukupali introduced death into Tiwi society. Purukupali fought with his younger maternal brother, Tapara, after the latter had seduced Purukupali's wife and her son had died as a result of neglect. Tapara offered to bring the child back to life, but Purukupali refused the offer and said that because his son had died, all people had to die. In his fight, Tapara injured Purukupali's leg with a forked throwing club. Tapara was hurt above the eye and transformed into the moon. Every month the scar left by the injury above the eye still can be seen on the moon. In one version of the myth, Purukupali's baby, Djinani, dies of starvation; in another, he

dies of thirst due to having been left in the hot sun, while Tapara and Purukupali's wife Bima were having sex in the bushes. Bima was grief-stricken: Her wailing sounds can still be heard, because she turned into Waijai, the curlew. Whereas Tapara might be seen as a symbol of regeneration—think of the waning and waxing of the moon—through his promise to bring Purukupali's dead son (Djinani) back to life within 3 days, Purukupali issued death: as his son had died, he said, all people would have to die. Such myths involving death and the moon, with the refusal of a regeneration to life as their theme, have been recorded across Australia.

Mortuary Rites and Death-Related Taboos

Belief is transformed into action through Aboriginal ritual. Ritual and Dreaming mythology are closely intertwined. Previously, many authors have noted a strict gender division in religious ritual activities, suggesting that male rites were sacred and secret, whereas female rites were profane. This perception is no longer endorsed, for women do play an important part in male rituals; they also have rituals of their own. In addition, much of the sacred ritual and symbolic imagery is of equal significance to men and women, particularly in life cycle rituals, a frame through which to perceive the world.

Nearly everywhere throughout Aboriginal Australia mortuary rites are carried out, and in some places, these rites are elaborate and extensive. Aborigines had no conception of a natural death, but if this belief was once universal, it is no longer adhered to in most cases. Expressions of anger and utterance of physical threats, however, are part and parcel of the ritual repertoire and mourning behavior in a number of places. Suspicions of homicide, including deaths as a result of sorcery, can be dealt with in an inquest, sometimes followed with either the victims' vengeance by physical or metaphysical means or compensation by the perpetrators. Wailing is often accompanied by gestures suggestive of the self-infliction of harm, which have to be stopped by others on the scene.

Customary, the personal name of the deceased becomes taboo for a period of time. The same accounts for recorded voices and images. Other mortuary taboos Aborigines might have to observe relate to food, sexuality, the corpse, personal belongings of the deceased, and places frequented by the dead. Cleansing rites with smoke, water, or both, can release them from these taboos. Sometimes mock fights also occur to this end.

The cycle of mortuary rites often has particular ancestral connections, relating to the deceased and participants, as its theme. They entail a division of labor and the acting out of various roles, commemorating the dead in song, dance, ritual calls, and gestures, as well as restoring the social fabric. Painted designs and sculptures can also figure prominently. Besides bringing forth the transition of the deceased from the world of the living to the world of the dead, the rituals are interwoven with other passages, such as the initiation of youths, whereas initiation and seasonal rites may involve aspects of the mortuary cycle. Rather than having clear-cut beginnings and ends, mortuary rites tend to be part of an ongoing social discourse, expressed in the lyrics of mourning songs.

Forms of Disposal

The various types of mortuary ritual in Aboriginal Australia, including the treatment and disposal of the dead body, reflect the Aboriginal view of death as a transition through which a person moves to another phase of existence. An important concern of mortuary ritual is to drive away the spirit of the deceased from the world of the living to the world of the dead. This may include partial or complete destruction of the deceased's remains and the deceased's material possessions.

There exists a great variety in the ways of disposing of the corpse, including in the intensity and duration of the process. These forms include interment and/or reburial, exposure on a platform or tree, desiccation or mummification, cremation, placing in a hollow tree, and in addition, the exceptional ritual consumption of a tiny bit of the corpse has also been reported. The modes of disposal are not mutually exclusive, and in some places several forms may occur successively. The type and duration of a disposal may depend on the social status of the deceased, the nature of death, and the desires, political aspirations, and organizational power of the survivors. The places where the spirits of the dead dwell continue to be of significance. For example, the living call out to the spirits to assist them in hunting and gathering, the location of the graves has a bearing on territorial

rights, and touching the sand of a grave of a relative is supposed to bring luck in playing cards.

Eric Venbrux and Anke Tonnaer

See also Death, Anthropological Perspectives; Deities of Life and Death; Funerals and Funeralization in Cross-Cultural Perspective; Mythology; Totemism

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Autoerotic Asphyxia

Autoerotic asphyxia (AEA) is the practice of preventing oxygen uptake to arouse sexual desire. Medical professionals are likely to refer to AEA as the inducement of cerebral anoxia—a lack of oxygen in the brain—while attempting to achieve orgasm. Other names include asphyxiophilia, hypoxyphilia, and sexual asphyxia, which focus on sexual desire and would include arousing the sexual desire of one's sexual partner(s) in the act, whereas AEA is limited to practices that are directed to one individual for the satisfaction of his or her own sexual desire. It seems to have caught the attention of the scientific community in the early 20th century when a description appeared in the 1902 volume of the *Annales d'Hygiène publique et de Médecine légale*. As a regular supply of oxygen is necessary for survival, AEA risks causing death and it is largely through such deaths that AEA is known. While AEA seems to attract morbid fascination for its combination of sexual pleasure and the taking of one's life in a single act, that it is known through death is important for considering the epistemology of AEA. Furthermore, death is often represented in the act of AEA, such as with photos or videos of apparently dead people, which means that as AEA is known through death, death is also known through AEA.

Descriptive Knowledge

People who practice AEA rarely discuss this publicly, but because it is a cause of mortality, it has required that those involved in investigating these deaths, particularly the police, coroners, and forensic pathologists, must describe and interpret scenes of fatality where AEA seems to have occurred. The minimum requirements for suggesting that AEA was being practiced are the presence of signs of masturbation and asphyxiation. While asphyxiation is likely to be the cause of death in most autoerotic fatalities, it is possible that signs of masturbation are either absent or missed and therefore that AEA is overlooked. John Quinn and Pauline Twomey report of a man, Mr. J. B., in a psychiatric unit in Ireland who, while appearing to present no suicide risk, had been found with clothing tied around his neck on seven separate occasions. The staff thought these were parasuicidal acts until Mr. J. B. revealed that he found that the asphyxiation enhanced his sexual desire while masturbating. Consequently, AEA may be overlooked for parasuicide or suicide, particularly in psychiatric settings and scenes of fatality.

Methods of asphyxiation include applying pressure to the neck; using ligatures for strangulation; fixing airtight materials, particularly plastic bags, around the head; and using chemicals, such as anesthetic gases and solvents, that remove oxygen. Inducing cerebral anoxia can be relatively simple, but elaborate devices can be constructed with

systems that are intended to halt the asphyxiation before it harms the individual involved.

Although AEA is understood to help excite sexual desire, scenes of autoerotic fatality often contain items that are not necessary for asphyxiation or masturbation but may be involved in the practice. Items include pornography; materials such as plastic and fur, which are used in fetishist practice; devices for stimulating the anus; photographs and movies apparently depicting scenes of death; and mirrors and video cameras that are in a position that would allow the individual concerned to watch him- or herself during AEA. Two elements that become more common as the age of the person involved increases are the presence of physical restraints (in addition to any ligatures for asphyxia) and wearing clothes indicative of the opposite sex, which are termed bondage and tranvestism, respectively. Like AEA, bondage and, in some cases, tranvestism are practices for attaining sexual gratification and such practices can be combined.

Forensic evidence describing AEA has accumulated since the first report in 1902, but there are many other sources that predate scientific interest in AEA. The most infamous literary examples are likely to be from the work of the French aristocrat Marquis de Sade (1790–1840), who was imprisoned for his violent and pornographic writing. An example that is most often used in reference to AEA comes from legal documents from a trail of the murder of František Kočzwara, composer of "The Battle of Prague." Kočzwara was from Prague but spent much of his time in England where he died February 2, 1791, in the company of Susannah Hill, a prostitute he visited in Vime Street, Westminster. Hill was tried for, and acquitted of, murder and reported that Kočzwara fastened one end of a rope to the doorknob and the other around his neck and asked her to let him hang for five minutes, which led to his demise.

A more contemporary example comes from Australia where Michael Hutchence, a member of the band INXS, was found dead in a hotel room in 1997 with a belt that had apparently been used for asphyxiation. The coroners ruled that Hutchence's death was suicide, but in the absence of a suicide note and the naked state in which Hutchence was found, others, particularly close family, have suggested that he died in the practice of AEA.

Epidemiological Knowledge

Estimates suggest that one in a million people practices AEA, but it is extremely difficult to provide accurate figures on the prevalence of AEA. Despite the variety of ways of expressing sexuality across cultures, much sexual activity remains concealed, and this is particularly so for AEA. Even if practitioners were happy to discuss their AEA with others, it is unlikely that they would feel compelled to seek medical help for something that enhances sexual pleasure. One of the most detailed descriptions of AEA in the living is the biography of Nelson Cooper by John Money, Gordon Wainwright, and David Hingsburger; unfortunately, this is only about one person and tells us little about people who practice AEA. Consequently, most of the epidemiological knowledge is from practitioners who die as a consequence of AEA.

There is much agreement that many autoerotic fatalities occur in men under 30 years old, but estimates of the total number vary dramatically. For example, for the United States and Canada figures range between 40 and 2,000 deaths for all age groups every year and it is difficult to decide which figures are most accurate. Many countries keep an annual record of mortality and its causes, but these records rarely contain reports of autoerotic fatalities. Mortality figures do report deaths due to asphyxiation and may even separate these deaths into accidental asphyxiation and suicide, but neither is limited to AEA. Family and friends may remove signs of sexual activity to avoid embarrassment, which could leave the scene looking like suicide. In addition, scenes of death require careful examination and may provide few clues that are easily interpreted.

Friends and family may help investigators build a picture of the deceased and explain the importance of clues found at the scene, but they may be unlikely to help with information of a sexual nature. More specifically, those involved in making reports of death are likely to give some consideration for the family and friends of the deceased and may be wary of raising the prospect that the activity causing death was sexual. However, some analysts of adolescent suicides suggest that almost 1 in 20 suicides and 1 in 3 hangings are related to autoerotic deaths.

Epistemic Considerations

Understanding of the epidemiology of AEA has been built upon analyses of instances of death and its causes. Consequently, knowledge of AEA has largely emerged through the death of practitioners of AEA, and it would seem prudent to attend to the importance of this for the epistemology of AEA. Crucially, there seem to be two, albeit entangled, epistemic considerations: the representation of death in (a) the practice and (b) the study of AEA.

First, death is often represented in the practice of AEA. Practitioners have been found with pictures, photographs, and films depicting people who appear to be dead or dying. In addition, practitioners have been found with devices that allow them to see themselves or parts of themselves in the act of AEA. As AEA is the practice of restricting air supply to arouse sexual desire, the distinctive element would appear to be the physiological response, the dizziness and euphoria that occur as a result of oxygen deprivation. The representation of death is not necessary for such a response to occur. Consequently, because depictions of death are not necessary for asphyxiation, it is probable that they have a more direct role in sexual excitation. Indeed, death from asphyxiation may be more than an unintended consequence as the risk of death or an experience of a greater proximity to death may be implicated in the stimulation of sexual arousal. The point is that representations of death may be part of the practice of AEA that is sexually exciting.

Second, death is represented in the study of AEA. As part of the collection of evidence, investigators take photographs and videos of death scenes. In addition, investigators draw pictures depicting the scenes or aspects of it and may even put together a mock-up of the original scene. In the study of AEA, researchers draw upon pictures, photographs, and stories for illustrative purposes. It would not be uncommon for a journal article or talk about AEA to start with a short story of a mother who discovered her son in a state of undress, surrounded by pornographic materials and bound with a device for causing asphyxiation. Similarly, photographs and pictures depicting autoerotic fatalities may be used throughout an article or talk, and in books, such images may adorn the jacket cover. As the representation of death would seem to be an aspect of AEA, the use of such images (both narrative and pictorial) in the study of AEA is not inconsequential. Lisa Downing and Danny Nobus pose that the source of such images often remains ambiguous. That is, it is not clear if the image is a mock-up, if it is of a scene of an autoerotic fatality, or if it is from such a scene. A story may be of a real death or it may be fictional, a picture may be of a person who has really died as a consequence of asphyxiation or it may be an actor pretending, and a picture may be one the investigators took at the scene or it may be one that was found at the scene. The representations of death used in the study of AEA seem to have a similar epistemic status to those representations used in the practice of AEA. As such, the images constructed, however that may be, in the study of AEA may have the consequence—intended or not—of arousing sexual desire.

It is unlikely that the researchers and investigators will ever dispense with such images of death. What this highlights, however, is that the morbid interest with which AEA is often received is a fascination with representations of death that are in some way sexualized. During the last half of the 20th century there were on average 10 cases of AEA reported in the academic literature every year. As death and sexuality are of concern to so many and yet manifest in such a variety of means, this interest with AEA is likely to continue because it combines both.

Peter Branney

See also Databases; Sex and Death; Subintentional Death; Suicide

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Awareness of Death in Open and Closed Contexts

In 1965, Barney G. Glaser and Anselm L. Strauss's study of the different awareness contexts of dying was the result of an extensive field study of how dying and death were treated in a number of American hospitals in the early 1960s. The four different awareness contexts portrayed by this study were to lay the foundation for an awareness of dying and death that resulted in a new paradigm.

In the first, *closed awareness*, dying patients do not know of or recognize their impending death because this information is withheld from the patients. Five structural conditions contribute to closed awareness: (1) the patients' lacking the experience to recognize signs of death, (2) physicians' not informing the patient that death is imminent, (3) the lack of discussion of death among family members, (4) the medical organization's not providing adequate information to the patient, and (5) the patients' lacking allies who would reveal the truth.

The second awareness is *suspicion awareness*. The patient does not *know* he or she is dying, but *suspects* death is close and also suspects the professionals are withholding information that would confirm this suspicion. Several structural conditions are supposed to account for this suspicion: (a) bodily changes in the patient, (b) changes in or termination of treatment, (c) cues from professionals or next of kin, and (d) the patient's being alarmed by the name of the care unit (i.e., the intensive care unit or oncology department).

The third awareness context is *the ritual drama of mutual pretense*. That is, the patient, professionals, and the next of kin know that the patient is about to die but pretend they do not know and hence act as if this were not the case. The structural conditions of open awareness are present here, but one of the parties expresses a desire to pretend that death is not impending and the other party (or parties) decides to play along in this drama. Two rationales for agreeing to mutual pretense on behalf of the professionals are found: (1) the patient wishes to pretend, and (2) the patient is easier to handle if the matter of death and dying is not openly discussed.

When both patient and professionals know the patient is dying and acknowledge this, there is an open awareness, the fourth context. Here different degrees of openness are found to occur. This includes whether death is expected, when it is expected, and how it will come about.

Further Contexts of Awareness

This fourfold analysis does not fully entail the complexity of awareness contexts, and further research has found elaborated versions of awareness. If a person acquires knowledge about impending death, but this knowledge is effectively blocked out, this results in *suspended awareness*. If the dying person oscillates between periods of open and closed awareness, this results in *conditional awareness,* in which the oscillation is triggered by different external or internal factors. Awareness of dying in the conditional sense can also be contrasted with the awareness of being mortal, an awareness that it is sometimes claimed we should have throughout life, that is, the idea about *memento mori.*

Paradigm Shift

The study by Glaser and Strauss described a situation in which closed awareness and withholding information were the norm for relating to dying patients. At the same time it was emphasized that death and dying were surrounded by a taboo, hindering open discussion and information. Through the efforts of thanatologists and pioneers within the hospice movement of the 1960s, a shift in this paradigm around death and dying started toward a generally more open climate, including calls for open discussion of death and dying and the recognition of the care of dying patients as an essential part of health care. In studies conducted by Elisabeth Kübler-Ross, awareness of dying was a necessary feature of being able to reach the stage of acceptance now deemed essential to providing patients with a good death. In the works of Dame Cicely Saunders, the ability to provide proper care for the dying patient also required openness of the topic of death and dying; closed awareness was no

longer considered effective in contributing to a good death.

The norm supporting open awareness is supported by a shift in the structural conditions of health care and medicine, wherein emphasis on patient autonomy has resulted in an obligation to always provide the patient with adequate information concerning his or her condition, including information about death and dying. However, research shows that the obligation to adequately inform the patient is interpreted as conditional by professionals who, to a large extent, continue to retain control over the disclosure of information. The norm of open awareness is found to be well in line with a modern role of dying, emphasizing the individual person's possibility to fashion one's own death, a factor that requires awareness of approaching death.

Establishing open awareness as normative results also in a shift in expectations for how patients should relate to death and dying. Not only being aware of impending death but also being committed to talk openly about death is labeled *full open awareness*.

This shift in awareness has resulted in discussion and critique of the new paradigm. In other cultural contexts, closed awareness is seen as a way to protect the dying person from distress. It is also found that patients oscillate between open and closed awareness to avoid threats and to handle relationships and thus control the level of awareness in a way that is tolerable to them. Within the context of full open awareness, that which is now interpreted as denial of death has been found to be a lack of interest in discussing death and dying; patients are unwilling to be constantly reminded they are dying. Different studies appear to balance this conflicting view by pointing out that the modern role of dying is still not generally accepted or practiced and is dependent on factors such as culture, class background, and age. Moreover, it is generally associated with specific conditions that affect awareness around dying and death, such as deteriorating mental faculties.

Normative Issues Around Awareness

The normative requirement that the dying should be aware of impending death gives rise to the question of whether that person should have a choice of such awareness of oncoming death. Psychological studies of defense mechanisms suggest that dying persons can regulate their awareness of oncoming death at a tolerable level. Moreover, Glaser and Strauss demonstrated how professionals can regulate the patient's degree of awareness. This raises questions about whether they should support open rather than closed awareness or some other awareness alternative. Whether dying persons should be made aware of death and dying is mainly a matter of norms and values concerning what is beneficial to the dying person and whether the dying person has ethical obligations that should be fulfilled even in the face of death.

Questions pertaining to what is beneficial to the dying person give rise to three types of arguments. First, awareness is instrumentally useful in that it enables the dying person to take advantage of the remaining time left—to prepare for death in different ways, take evasive actions against death, or just focus on the things that will bring value to one's life in the time one has left. Second, awareness will be conducive to self-determination, freedom, and control over the dying person's life. Third, awareness is valuable in itself insofar as it is an essential part of a good life.

The instrumental value of awareness is dependent on the value of what is achieved, whether we can achieve this regardless of being aware and whether the price of awareness is worth the benefits achieved. However, a price is exacted for this awareness of oncoming death in the form of a lower well-being and a lack of motivation. In contrast to this type of argument, it has been suggested that it is possible to take evasive action without being fully aware of oncoming death. It has been argued that the preparations the dying person can do should be made earlier in order to safeguard their benefits, or perhaps these are not important enough to warrant attention. It has also been argued that insights into the limits of time might bring stress and paralysis, hindering the person from using the time left to achieve quality of life.

That awareness, conducive to self-determination, freedom, and control, is important to allow one to plan and realize these life plans. It is also related to the fact that such knowledge allows one the freedom to act within reason but without consequence, and in the face of death, that which may have caused fear now loses its hold. But it has also been

posed that relevant information leads to a loss of initiative.

Moreover, it has been argued that avoidance of the negative experience of awareness is not useful to the extent that one cannot use this knowledge to alter one's own life or that of others for the better.

That the dying person should recognize an ethical obligation to become aware of impending death is associated with the fact that this might be instrumental in benefiting or fulfilling obligations toward other people. If the dying person and next of kin adopt different awareness attitudes toward death and dying, this can result in the lack of open communication, such as not being able to engage in taking an appropriate good-bye. However, it has been emphasized that this is dependent on a certain expressivist view of relationships in which close relationships imply that we share intimate thoughts and feelings. It has also been argued that if the parties adopt a common attitude of closed awareness or denial, this might cause the relationship to continue more smoothly.

In conclusion, the shift in paradigm from a closed to an open awareness context surrounding death and dying has been supported by reference to values and norms relative to how a dying person should be treated medically and otherwise. However, research and discussion of open awareness provide equivocal support for such a paradigm, and in relation to the dying patient the matter of awareness calls for a continued discussion of what is beneficial to the patient and the next of kin.

Lars Sandman

See also Appropriate Death; Life Review; Psychological Autopsy; Symbols of Death and *Memento Mori*

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Banshee

The banshee is the Irish supernatural death-messenger par excellence. Regarded as a family messenger of death, this female spirit is said to cry when a member of Irish family is about to die, at home or abroad. Belief in a female supernatural being foreboding death is an ancient cultural inheritance in Ireland. In the literature of early Ireland in the Irish language such beings appear in the context of imminent death, and the motif has persisted through the centuries in Irish poetry and prose.

A supernatural female foreboder of death has also appeared in works in the English language in Ireland for a couple of centuries. In *Castle Rackrent* published in 1800, Maria Edgeworth notes that in the previous century the great Irish families had a Banshee, but their presence was no longer evident. In representing the banshee as an element of past belief on the part of the Anglo-Irish aristocracy, Edgeworth makes no mention of the persistence of belief in such a being among the people at large in her time—something which she was likely to have been aware of in view of her knowledge of the beliefs and customs of the peasantry.

Other writers also make mention of the banshee in the course of the 19th century, but their accounts are general in nature and often strive to provide an antiquarian-type interpretation of the belief. Few of these analysts acknowledged that rich and varied oral traditions of the banshee were current at the time of writing, in both English and Irish languages, which would have added substance to their accounts and provided a clear picture of the complex nature of the belief. Thanks to the efforts of the Irish Folklore Commission and its successor institutions, a large body of such traditions was amassed in the course of the 20th century, and field work continues to complement and corroborate them in the 21st century. It is thus possible to explore the richness of ideas about the banshee prevalent in the oral traditions of the Irish people in the 19th and 20th centuries, and to assess the role that these traditions played in the lives of those who held the belief. Such a substantial and varied body of source material also enables researchers to determine the main components of the banshee belief in Ireland in recent centuries, to assess regional variation in the traditions concerning her, and to explore her manifestations and roles in earlier centuries.

The names attached to supernatural beings are usually important indicators of the main traits associated with them in the oral traditions of the people. The names can also point to regional variation in traditions about such supernatural beings, and they can be of assistance in trying to determine the age, origin, and functions of the belief concerning them.

Irish Tradition and the Banshee

The Irish supernatural death-messenger is known by a variety of names in different parts of the country. The most common term, found throughout Ireland, is *bean sí* (anglicized "banshee"), meaning "woman of the otherworld," clearly

indicating that she is considered to be of female gender and of supernatural origin. In view of the wide distribution of this appellation for the supernatural death-messenger and because it is found in areas where other local terms are prominent, it can be assumed that it has been the most common and most widespread name for this supernatural being for many centuries.

In parts of southeastern Ireland the banshee is also known by various dialect forms of the word *badhbh,* the name of a goddess, usually a goddess of war, appearing in medieval Irish literature, while in the South Midlands she is called *badhb chaointe* "keening or lamenting *badhb,*" an appellation reflecting her origin and role behavior. The distribution pattern and various dialect forms of the word *badhbh* indicate that these terms are of appreciable use in the areas where they have been recorded.

The remaining traditional name for the banshee is *bean chaointe,* "keening woman," a term that is heard in parts of counties Tipperary, Limerick, and Mayo and may once have been more widespread. This name refers specifically to supernatural being's role behavior—lamenting—and may have been influenced by a similar designation for a human woman who lamented the dead. It may also have given rise to the idea found occasionally in the oral tradition that the banshee was, in origin, a former human keening woman who was obliged to continue keening after death because of some misdemeanor in this life. This explanation is not very prominent, however, and despite the appellation *bean sí*/banshee, neither is the idea that she is one of the fairy folk. Tradition-bearers clearly distinguished between the banshee, who is depicted as a solitary being and a messenger of death for certain families, and the fairies, who are regarded as social beings with a range of activities and relationships that does not include the foreboding of death, and they are also not particularly attached to families, or indeed, human beings in general.

Actually the question of the origin of the banshee has only occasionally been raised by tradition-bearers. Yet, the idea that she is connected in a special way to particular families—as an ancestral figure—is a central aspect of the traditions concerning her.

The banshee is said to follow certain families; that is, her connection with them extends from generation to generation. These were particular noble Irish families, and she was said to follow their chieftains or heads. She is also connected to land, patrimony, and identity, thus echoing the poetic evocation of the s*í-bhean* or *bean sí* with noble Gaelic, or Hiberno-Norman families in the 17th century when confiscations and plantations by the English government led to fundamental changes in land ownership in Ireland and in the ethnic, religious, and linguistic profile of much of the country in that century.

Thus traces of an ancestral female figure, with vestiges of the role of a patron goddess, would appear to be discernible in the oral traditions of the death-messenger. Such traces are, of course, older than the 17th century, and analogies can be suggested with other foreboding or lamenting female figures in medieval Irish literature who were concerned for the fortunes of specific noble families or individuals. In the 8th-century prose tale *Táin Bó Fraích*, the impending death of the hero Fraoch mac Idath is announced by the cries of otherworld women, while the goddess Mór Mumhan laments over the grave of her mystical spouse Cathal mac Fionghuine. In later texts his own death is foretold to Brian Ború, High King of Ireland, at the battle of Clontarf 1014, by Aoibheall of Craig Liath, patroness of the Dal gCais sept (clan), County Clare.

Other traits of the death-messenger of modern folk tradition also support this analogy with female sovereignty figures of medieval literature: her appearance both as an old woman and, to some extent also as a tall, vigorous, beautiful young woman, and her washing activity. The latter trait is found in the folklore of parts of western Ireland, particularly in 20th-century oral tradition of County Galway, where the death-messenger is portrayed as a washerwoman beetling clothes in a stream on the eve of the Battle of Aughrim 1691—an activity attributed to the war goddess *badhbh*, said to forebode violent death in battle by washing the blood-stained garments of those fated to die.

It is probable, therefore, that the death-messenger of modern folk tradition originated from the idea of a patron goddess with a variety of contrasting attributes and functions, including the foreboding and announcement of death. It is the former trait, that of death-foreboder, which is emphasized in the death-messenger tradition, and throughout

Ireland she is popularly said to perform that function by crying and lamenting.

The most outstanding characteristic of the banshee in her role as herald of death is her sound. This is usually described in the oral tradition as a female-type inarticulate cry full of sorrow and grief for the person about to die. The banshee is thus thought to be well disposed to the dying person, and her behavior is generally considered to be nonviolent and human-like. So strong was the belief in the death-messenger-as a foreboder of death, it was generally accepted that if a seriously ill person was "followed" by the banshee that he was fated to die once she had cried; in fact, some people held that such a person could not die until the manifestation of the supernatural death-messenger had occurred.

Contemporary View of the Banshee

The dominant popular image of the banshee is as a female figure who always appears alone. She is imagined to be a small old woman, dressed in a long white cloak, with long white hair, which she is almost invariably combing. This image of an old woman probably springs from her connection with death, her perceived ancestral connection with the family she follows, and her role as an outdoor or nature being. The combing motif, which has given rise to an oral legend about how the banshee lost and recovered her comb, also links the banshee with otherworld women similarly depicted in connection with death in medieval Irish literature.

The betwixt and between times—midnight, dawn, and dusk—are the times particularly associated with the manifestation of the death-messenger. These dark and gray hours are especially associated with supernatural beings connected with death, and they are also times when light and sound conditions favor supernatural interpretations of phenomena to which natural interpretations would be given if they occurred in the daytime. Thus, if someone were known to be seriously ill, the supernatural death-messenger would easily spring to mind if an unexplained plaintive cry was experienced at these times.

Most manifestations of the banshee are said to occur in Ireland, usually near the home of the dying person. The cry might also be located near unusual nature formations, like hills or rocky eminences, which appear to have stirred people's imagination and would have been prominent landmarks in the locality.

The death-messenger is often heard near water, such as at wells, lakes, and rivers. The latter formations were also often prominent landmarks in localities or formed boundaries between farms, parishes, or even counties. Because sound travels along water, once it has been associated with the death-messenger it is easy to imagine that the supernatural being who was imagined to emit the sound was also located near to water.

The banshee usually appears in Ireland, but some accounts also refer to the announcement in Ireland of the deaths of Irish people overseas, thus acknowledging deep family roots in the old country. This is especially the case in relation to death in the United States, a country to which Irish people emigrated in large numbers in the 19th and 20th centuries.

It is those concerned with a death, at family and community levels, who usually hear the banshee, rather than the dying person. This is in accordance with the general belief that the dying person does not experience the death-messenger. It also reflects prevailing attitudes toward death and dying in traditional Irish society, in which the care and attention of the dying person and the arrangement of the obsequies were the responsibility of the family and the community.

Despite the almost inevitable weakening impact of changing attitudes toward death in Ireland, on beliefs and customs traditionally associated with the final crisis in life, belief in the banshee as a foreboder of death in certain families seems to have retained a fairly tenacious hold on people's imagination. Such a deep-rooted and obviously significant belief is likely to remain part of the Irish cultural inheritance for ages yet to come.

Patricia Lysaght

See also Deities of Life and Death; Hospice, Contemporary; Popular Culture and Images of Death; Symbols of Death and *Memento Mori*

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Baptism for the Dead

A single verse in the Bible speaks of baptism for the dead: Chapter 15 verse 29 of Paul's First Letter to the Corinthians, itself the longest focused textual reflection on death in the New Testament. This entry explores this much ignored verse, the imagery of death in ordinary Christian baptism, and how vicarious baptism became foundational within Mormonism and fostered its program of genealogy.

Textual Conundrum

This Corinthians passage has often been included in funeral services because it highlights the centrality of resurrection within Christianity. Written to oppose arguments against resurrection, it links Jesus's resurrection with the future resurrection of believers, convinced that Christianity devoid of resurrection is vacuous. Just when concluding his depiction of a future when sin and death are conquered and God is supreme, he cites the practice of those who are "baptized for the dead," emphasizing that such a rite would be pointless without the ultimate resurrection of the dead. For Paul, that rite demonstrated belief in resurrection; otherwise, the practice would deny its underlying motivation. Whatever its original meaning, this text's existence within scripture allowed subsequent commentators either to ignore it as inappropriate to need, as has often been the case, or to breathe new life into it as occasion demands.

John Calvin (1509–1564), the Protestant reformer, was but one who pondered vicarious baptism, well aware that the early Church Fathers Ambrose (339–397) and Chrysostom (347–407) and others had assumed the text referred to the custom, albeit rather superstitious and corrupt, of baptizing a living person at the graveside of some unbaptized Christian who had suffered an unexpectedly sudden death prior to baptism. Calvin not only alludes to various interpretations but also tells how he changed his mind over this text. He could not believe that Paul would ever allude to something with which he personally disagreed simply to have an example to prove a point. Calvin's early view had been that the text was a general indication that baptism was an important aspect of the Christian life as far as eternity was concerned. All that baptism embraced would be realized in the afterlife world of the dead: In that sense baptism was "for the dead." But then Calvin changed his mind, accepting the text as referring to Christians who, while still learning about the faith as catechumens were not fully prepared for baptism, discovered that they were soon to die, perhaps of a terminal illness. Now, despairing of life, with baptism of no use to them in this world, they saw themselves as "dead people." In being baptized for the dead, they were being baptized as and for themselves as people as good as dead. This would be a comfort to them and an example to their healthier fellows on the value of baptism.

Baptism at Large

It is certainly true that baptism was profoundly important as a mark of full identity within early Christianity as within its subsequent history. Integral to its theological meaning has been an interplay of the ideas of life and death portrayed in the image of the resurrection. To be baptized was to be associated with the death and resurrection of

Jesus. The water of baptism was, among other things, like the grave. One entered it, "died," and emerged as though from the grave. While baptism mirrored what had already happened to Jesus, it foreshowed what would happen to believers at the future day of resurrection. Baptism was also a form of rebirth.

Other symbolic associations included the theological idea that human beings lived a life "in the flesh" and as sinful creatures until such time as they were revivified by the power of God's Holy Spirit so as to live "in the spirit." Paul invoked the motif of the first Adam who disobeyed God, died, and brought death upon all humankind while Christ, as the second Adam, was obedient to the point of his own death but, through his resurrection, now brought life through a future resurrection for humanity (Romans 5:12–21). These and other motifs of deliverance invested the act of baptism with powerful notions of salvation. So, when Paul spoke of some as being "baptized for the dead," he touched a vibrant topic. In much contemporary Christianity, however, whose rites have developed from traditional and long-established baptismal liturgies and include many allusions to death to sin, association with Christ, deliverance from slavery, and spiritual rebirth, the motif of "baptism for the dead" finds no place, except for one major case, that of Mormonism.

Latter-day Saints

Joseph Smith (1805–1844), founder of the movement that came to be called The Church of Jesus Christ of Latter-day Saints, popularly known as Mormonism, believed God had revealed to him the fact that living individuals could be baptized for the dead, in the sense of being baptized on their behalf. This vicarious baptism, in which a living person stands proxy for a deceased individual, became framed by a much wider theology of life, death, and afterlife and directly answered the question of the destiny of millions who died before hearing the Christian message or being able to respond to it.

From its inception in 1830 until Joseph's death in 1844, Mormonism was transformed from an essential Protestant Adventism, awaiting the imminent Second Coming of Christ and preparing a kingdom for his arrival in America, to a people possessing a growing interest in ritual performances conducted in sacred secrecy that endowed worthy members with a status guaranteeing them an identity as kings and gods in worlds they would inhabit after their death and resurrection. Joseph saw the universe as operating by well-defined principles, one of which ensured that revealed rituals performed in designated sacred places under the conditions of "time" and earthly mortality would have a direct effect within the afterlife domains of eternity. These included baptism, ordination, and a form of sacred marriage and sealing together of partners for eternity; marriage was not only until death. One key ritual was that of Endowment. This taught basic truths of creation, the fall, and the redemptive atonement effected by Jesus within a wonderful Plan of Salvation devised before the earth was actually organized into its habitable form. Endowment was a form of death-conquest that gave to those who worthily maintained their covenantal vows taken out with God power to survive death and flourish in the eternal postmortem worlds of eternity. Both the principle of earth-based ritual that might secure a heavenly destiny and the recent origin of the church fostered a degree of urgency concerning those who had died before this church restored to the earth truths and rites that had been removed by God shortly after Christ's death and resurrection. Joseph's revelations covered these problems, as documented in *The Doctrine and Covenants* ([DC] 124:33), a book of divine directives that included instructions to build special temples as locations for baptisms for the dead. This idea of vicarious baptism excited early Mormons who rapidly practiced it in rivers. Further revelation, however, soon brought clear directives restricting it to enclosed sacred places.

Vicarious Baptism for the Dead

Joseph had addressed himself to the idea of baptism for the dead during a funeral sermon in 1840. This teaching touched the hearts of many Latter-day Saints because it enabled them to do something of religious importance for the dead in general and for their own relatives in particular. An initial and relatively indiscriminate baptism for dead people soon passed into a more disciplined endeavor focused on one's family. This involved formal gathering and keeping genealogical

records of the dead as basic information for use in the vicarious baptism. Records were and are taken of all that took place. It was established that men should be baptized for male kin and women for female family members. Baptism for the dead now became the rationale for the now famous project of genealogical research compiling immense amounts of information on the dead gathered from church and civic records the world over. It also reinforced the Mormon ideal of extended family life, with the extension embracing ancestors as well as descendants.

With time and resources the Latter-day Saints built their initial large-scale temples, such as the one in Salt Lake City, installing a baptismal font at the basement level of each edifice. This circular bath-like container facilitates baptism by total immersion and stands on the backs of 12 metal oxen representing the Twelve Tribes of Israel. Many countries of the world now possess one or more such temples, buildings quite distinct from the thousands of meeting houses of Mormons that provide the basic organization for weekly worship and that contain rather ordinary fonts for the baptism of the living.

Many non-Mormons often misunderstand vicarious baptism, thinking that it somehow forces the dead to become Mormon. Nothing could be further from the truth, as Latter-day Saints place an absolute value on freedom of choice or personal agency. What vicarious baptism does is demonstrate the love and concern of the living for their dead as they provide them with the opportunity to appropriate in eternity the earth-based baptism conducted on their behalf. A great deal of time and effort is expended both in obtaining kinship records for as long ago as is feasible and in visiting a temple to engage in this "work" on behalf of the dead. Once the baptism has been performed, it becomes possible to conduct other rites for the dead so that they need not lack any advantage available to the living. In many respects this extensive vicarious work is summarized in the initial baptism for the dead and highlights the fact that the Church of Jesus Christ of Latter-day Saints is, essentially, a church grounded in issues of death and its transcendence. Here Mormonism takes traditional Christianity's interest in death and resurrection a step further, personalizing it in a grand theory of the individual family and its eternal bonding in a destiny to become kings and gods ruling over eternal worlds.

This large-scale institutional genealogical research and vicarious ritual practice should not, historically, be totally removed from Joseph Smith's profound grief following his elder brother, Alvin's, sudden death, when the officiating Protestant minister raised doubts over Alvin's heavenly destiny. This was when Joseph was about age 18 and some 7 years before he founded his church in 1830. He later spoke of his youthful heart as swollen and almost bursting with pangs of sorrow at Alvin's death. In 1836, when the new temple at Kirtland, Ohio, was being consecrated, Joseph has a vision in which he sees Alvin in heaven alongside divine figures (DC 137:5). This seeming paradox of Alvin's heavenly location despite his having died before the church was founded and without having been baptized is likely to have influenced ideas on baptism for the dead. This case shows how issues of death and changing cultural contexts could revitalize a biblical text that had laid relatively dormant for nearly 2 millennia.

Douglas J. Davies

See also After-Death Communication; Apocalypse; Christian Beliefs and Traditions; Eschatology; Resurrection

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Bereavement, Grief, and Mourning

The word *bereavement* is the noun form derived from the verb *bereave,* an Old English word that first appeared in 888 C.E. in King Alfred's translation of *The Consolations of Philosophy*. Since around the year 1650 the term *bereft* has referred to loss of immaterial possessions such as life and hope, whereas *bereaved* denotes a loss of a significant other such as a relative through death. The term *bereavement* is used to denote a condition of being bereaved or deprived.

Grief has multiple meanings, all of which deal with the subject of hardship, suffering, injury, discomfort, mental pain, and sorrow. The earliest citation for grief as some form of hardship or suffering is found in Middle English used in the year 1225; grief in the sense of sorrow as a result of loss or personal tragedy first appeared in Middle English in 1350.

The word *mourning,* derived from the verb *mourn,* first appeared in the same Old English manuscript in which *bereave* was used. To mourn is to express one's grief, to lament someone's death, to experience sorrow, grief, or regret.

Dimensions of Bereavement

Bereavement has a holistic or multidimensional impact. Scholars from philosophy, psychology, sociology, and psychiatry point out that bereavement manifests itself physically, emotionally, behaviorally, cognitively, interpersonally, and spiritually. The following examples serve to illustrate:

- *Physically* a bereaved person may experience fatigue, chills, and diarrhea.
- *Emotionally* a bereaved person may feel guilt, anxiety, loneliness, and fear.
- *Behaviorally* a bereaved person may experience bouts of crying and may have trouble sleeping and eating.
- *Cognitively* a bereaved person may have difficulty concentrating and remembering and may be flooded with intrusive images and thoughts.
- *Interpersonally* a bereaved person may remain isolated from others, may find others uncomfortable in his or her presence, and may lash out unpredictably at others.
- *Spiritually* a bereaved person may question the meaning of existence, lose hope, and feel adrift in the world.

The contributions of two scholars, namely Sigmund Freud and John Bowlby, dominate Western cultural thinking about bereavement, grief, and mourning. Since the mid-20th century most writing on bereavement, grief, and mourning emerges from responses to Freud, Bowlby, or both. Freud's seminal paper, translated as "Mourning and Melancholia," involved his efforts to delineate more carefully what today is referred to as clinical depression. Freud compared and contrasted the normal responses to irreparable loss that are found in grief to the pathological responses found in clinical depression. For Freud, when we have a deep emotional investment in another person and that person dies, we engage in denial, not accepting that loss, and fight against relinquishing our emotional investment. Bereavement resolution involves intense, gradual work to demonstrate that the loss occurred and to free one from the emotional attachment placed in the deceased person.

Freud posed that bereavement recovery requires three arduous tasks. First, it is essential to encounter all reminders of the deceased so that eventually they don't produce emotional pangs. Second, it is imperative that one detach emotionally from the person who has died. Third, it is important to construct an emotionally neutral mental representation of the deceased that makes possible remembering the person without suffering the distress of bereavement. Freud's depiction of dealing with bereavement has become known as "grief work."

Dimension of Grief

Freud emphasized that grief is a normal response to the death of a loved one, and he said were it not for personal acquaintance with the effects of bereavement, it would strike him that the intense distress of the griever is pathological. What normal bereavement requires is time and hard work, not professional intervention. Bereavement is a

human misfortune, rather than a pathological condition, and Freud emphasized that a griever does not need referral for professional help.

Erich Lindemann, an American psychiatrist, attempted to build on Freud's idea of grief work when he worked with over 100 persons, most who were bereaved following a massive fire at a Boston restaurant in the early 1940s. Based on this effort, Lindemann's research paper became influential among grief counseling practitioners and for scholars writing about bereavement. Lindemann noted that grieving patients would begin to recover from acute grief once they (a) allowed themselves to feel the distress associated with their bereavement and (b) openly talked about their grief. Ignoring Freud's assertion that grief work required time, not professional intervention, Lindemann made Freud's notion of grief work the standard for understanding what grieving entails.

Lindemann's identification of an acute grief syndrome, a set of seven associated symptoms, has become a landmark contribution. The seven symptoms are the following:

1. Somatic distress occurring in regular waves and lasting from 20 to 60 minutes and manifest in such ways as shortness of breath, trouble eating, utter exhaustion, and sighing
2. A sense of unreality since the death
3. Increased emotional distance from others
4. Intense preoccupation with images and thoughts of the deceased
5. Feelings of guilt
6. Irritability and unprovoked outbursts of hostility
7. Loss of patterns of conduct manifest in such ways as restlessness, difficulty making decisions, aimlessness, and difficulty staying focused

Lindemann also invented the concept "anticipatory grief reactions," which has influenced scholars' speculations, though not without controversy. The concept described the reactions of some women whose expectations their husbands would die in combat in World War II led the women to grieve the men's deaths and emotionally detach even though their husbands had not lost their lives. A contemporary focus of this concept is on grief reactions to learning a loved one is terminally ill.

John Bowlby was a British psychiatrist whose influential thinking about bereavement, grief, and mourning was stimulated by the British government's solution to protect children from being killed at the height of the Nazi bombing of England's cities. The British government separated children from their parents, sequestering these children in the interior of the country. Bowlby was asked to examine the effects separation from parents had on the children, and from this examination his view of bereavement emerged. Whereas Freud referred to psychic processes to explain responses to irreparable loss, Bowlby turned to ethology and to Darwin's thinking on evolution. Maintaining that the survival of mammals depends on close bonds established between infants and caregivers, Bowlby believed that attachment bonds are biologically hardwired, so to speak, into the human species, and the types of attachment a youngster develops with caregivers influence the kinds of relationships that individual will form over his or her life span. The three basic types of attachment bonds identified include secure bonds and two types of insecure bonds: (1) anxious/avoidant bonds and (2) anxious/resistant bonds. A child's responses upon being reunited with parents are influenced by the type of bonds between the parent and the child: Secure children show great pleasure at being reunited, avoidant children seem distant, and resistant children show hostility.

Bowlby used the construct of attachment bonds as his primary theoretical explanandum. Bereavement, grief, and mourning represent naturally occurring responses when attachment bonds are sundered. Thus, bereavement has a fundamental social basis in Bowlby's thinking.

Kenneth Doka's concept of "disenfranchised grief" extends this social context for bereavement thinking. Specifically, two social judgments are noted: (1) Some losses are considered marginal, illicit, or immoral, and (2) grief over such losses is proscribed. Examples include grief over miscarriage, the death of a pet, death of a mistress, and death of a homosexual partner.

Empirical data demonstrating various types of attachment bonds influence contemporary thinking about bereavement. Secure attachments have

been found to characterize normal bereavement responses. Types of attachment concomitant with different styles of coping with stress produce different responses to loss. Bereaved persons whose bond to the deceased had been secure are flexible in their response to loss; persons with insecure attachments exhibit constrained thinking and action. In particular, insecure attachments are thought to produce bereavement complications, such as the difficulty experienced in socially constructing the meaning of the loss. Meaning reconstruction in the face of bereavement is at the heart of the thinking of several influential scholars. What is at stake is relearning one's relationship with other persons, with the world at large, and with oneself. This relearning may require developing completely new frameworks or schema for understanding existence, and in other cases may only require making a loss fit a current conceptual framework.

A Process Model of Grieving

Bowlby described the grieving process in terms of phases:

1. *Numbing phase*. In this first phase, the bereaved person seems incapable of comprehending the loss. A person will say such things as, "I can't believe this has happened."
2. *Yearning or searching phase*. In the second phase, the bereaved person seems preoccupied with thoughts and feelings about the deceased and by a desire to recover what has been lost.
3. *Disorganization and despair phase*. This third phase emerges as the bereaved person realizes the dead person cannot be recovered. Apathy may set in as the person struggles to find ways to cope with an irreparable loss. The challenge is to discard familiar patterns of thinking, feeling, and acting.
4. *Reorganization phase*. The final phase of Bowlby's model denotes a time when a person begins redefining his or her identity and place in the world. Such reorganization not uncommonly requires learning new roles, as when a middle-aged widow returns to the workforce after a 20-year absence or a widower learns how to cook and do laundry.

J. William Worden, an American clinical psychologist, developed an influential model that explains coping with bereavement in terms of four tasks:

1. Accept the reality of the loss.
2. Work through the pain of grief.
3. Adjust to an environment in which the deceased is missing.
4. Withdraw emotional energy and reinvest it in another relationship.

Empirical research challenged the original conceptualization of the bereavement resolution process, principally from advocates who argue that continuing bonds was a common bereavement outcome, thus causing Worden to revise task 4, that is, to emotionally relocate the deceased and move on with life. The rephrasing, while still very close to Freud's overall idea of letting go, suggests the possibility of maintaining a continuing attachment to the deceased.

Some scholars challenge the notion that emotional detachment from the deceased is necessary for bereavement resolution. Thus, it is proposed that a correction called "continuing bonds" is required. It is not uncommon for bereaved persons to constructively face the loss of a significant other while remaining attached to the person who died. This latter emphasis on continuing bonds has captured the attention of many scholars and clinical practitioners, leading in turn to the following irony: Whereas traditional views portrayed ongoing attachment as pathological, some experts argue that a lack of ongoing attachment bonds is an indicator of pathology.

The Dual Process Model of Coping

The dual process model of coping with loss has been proposed as a refinement to the notion of grief work. Clinical work with bereaved persons indicates two distinct processes, not merely a confrontation with distress but also enabling bereaved persons to adapt to their loss. Grief work is accepted as being important to enable one to focus on the distress of one's loss. However, it is also important to attend to other aspects of life. The dual process model asserts that a part of

bereavement requires us to experience a loss orientation (the grief work notion) and also to establish a restoration orientation in which life goes on. Bereaved persons oscillate between these orientations as they deal with their bereavement. Such oscillation is normal; it is what people do naturally. Thus, any bereavement care program that emphasizes only grief work would be incomplete.

More recently, scholars who advocate the dual process model have sought to refine the model by further evaluating types of attachment bonds. Whereas empirical data indicate that secure attachments prior to a death can lead to bereavement resolution with ongoing attachment after the death, in cases of insecure attachment bonds prior to the death, a letting go or detachment is in the best interest of the griever. In short, not all deaths produce bereavements with ongoing attachments, nor should they.

David E. Balk

See also Cemeteries, Pet; Death, Psychological Perspectives; Death, Sociological Perspectives; Denial of Death; Grief, Types of

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Bioethics, History of

The history of bioethics relating to death and dying is, like any philosophical endeavor, about questions and answers. The fundamental challenge to developing a cohesive and consistent approach to such a complex history is that the questions are raised in a pluralistic context in which participants enter the discussion with a variety of religious, ideological, philosophical, educational, and vocational backgrounds. These differences can serve to open new perspectives on a problem, and the history of bioethics is, in part, one of grappling with diverse approaches to moral issues that yield equally diverse responses. These differences can lead to significant impasses, as frequently the end point of a discussion is not an agreement to continue the discussion but rather is a concrete action, one that perhaps must be undertaken with some urgency and may be irrevocable—examples of such include withdrawal of a ventilator, stopping hydration or nutrition, enrolling a dying patient in a research trial with a significant burden of involvement with medical institutions, or actively participating in the death of a person. Such a practical conclusion to a discussion with such high stakes—human death is often at the center of the struggle—lends great significance to this history, and a number of attempts have been made to distill principles that are broadly applicable and comprehensive.

Significant Historical Events

Of the historical events shaping this effort, several have been seminal in the development of contemporary understanding of bioethics as it relates to death and dying, as well as to the structure of research involving human subjects facing potentially lethal diseases. In the United States, one of the earliest influences in the history of ethics—affecting the evolution of ethical codes

that offer guidance in medical decision making—was Dr. Benjamin Rush from Philadelphia who had great interest in moral issues around the time of the American Revolution, issues he addressed in lectures to medical students at the University of Pennsylvania. His work led to the Second National Medical Convention in the mid-1800s in which a committee was charged with drafting a code of medical ethics. Though the code of ethics of the American Medical Association that resulted from this effort had its critics, it was largely praised by the medical community. As new technologies (such as anesthesia and advances in surgical techniques) carrying both benefit and risk were developed, ethical issues arose centering around both the transformation of medicine into a scientific discipline and the idea of physician competence as the basis for ethical evaluation. During the 20th century, authority over patients shifted from the locus of physician duty to that of patient rights, a fact that affected subsequent work significantly. The American Medical Association Code of Ethics underwent several revisions, changing in concert with the evolution of the medical profession, which had achieved a firm position in society. This code, which has deeply affected debates over such issues as abortion, withdrawal of medical support, and euthanasia, is considered central to the medical establishment's vision of itself.

There have been a number of important challenges to the assumption of ubiquitous professional virtues and the moral reputation of the medical establishment. Some of the most important have occurred in the context of research; others in the context of caring for patients who have lost functions considered basic to meaningful life or patients who are suffering human moral abuses—such as those uncovered in the Nuremberg trials, the Tuskegee Syphilis Study, and the Advisory Committee on Human Radiation Experiments—have led to important questions about this assumption. The practical yield has been the production of highly influential documents such as the Belmont Report, the Declaration of Helsinki in its several versions, guidelines produced for the international arena by the Council for International Organizations of Medical Sciences, and, most recently, the adoption of the Universal Declaration of Bioethics and Human Rights in October 2005 by the United Nations Educational, Scientific and Cultural Organization. Common to these efforts are principles such as respect for persons, beneficence, and justice, which apply in both clinical medicine and medical research.

Principle-based deliberation and debate has helped to clarify the issues at stake and to attempt to provide common ground for discussion across pluralistic boundaries. It has also been criticized as being inadequate for addressing issues of such complexity and nuance. For example, casuistry, or case-based ethics, asserts that the principles always follow upon cases, instances, and concrete particulars. Bioethics properly proceeds from cases to categorical principles, not the other way around. Casuists argue (after Aristotle) that ethics is not and cannot be a science. It is rather a field of practical wisdom, a field that grows out of experience that in turn yields a recognition of significant particulars and informed prudence. A second important source of criticism of principlism, communitarianism, also derives from Aristotle. This approach argues that apart from agreement upon certain goods and goals, there is no rational way to reach moral agreement. For example, within one community, individual autonomy might be an important good, while another community deriving from a different cultural background might identify goods such as family obligation or religious authority as more weighty than that of autonomy. This weighing of goods might yield very different approaches to ethical decision making. From inside of a community, such a weighing of goods makes sense and might function as a basis for decision making. However, communitarians argue that there is no "view from nowhere" outside of a particular community that allows one to demonstrate the superiority of one community's view over another's.

Thus the history of bioethics draws from long religious and philosophical histories, from deliberative responses to events (as with the U.S. congressional response to the Tuskegee Syphilis Study), from law, and from the adaptation of past ethical responses to new situations, which are usually analogous in some respects, but which—often because of new technologies—have novel elements that present dilemmas.

Bioethics and Its Relationship to Death and Dying

Several important events have shaped bioethics as it relates to death and dying. One of the most fundamental ethical issues is the very definition of death. Two centuries ago, because of fears about premature burial, laws were passed requiring delay in burial. According to frightening tales, exhumed coffins revealed evidence that people had been buried alive. When is a person dead? We now know that death occurs in stages, a fact that underscores the importance of the philosophical dimension mentioned earlier: Is death when the person ceases to be, when the heart stops beating, or when all cellular activity comes to a halt? These three questions yield three different "times of death." The time of death is a moment of immense emotional, spiritual, and pragmatic significance. We do not take organs from the nondead, so it matters whether organs may be taken from one without brain activity versus one with no cellular activity, because the former is an organ donor who might save a life, whereas the latter might, at most, be able to donate corneas. Kansas in 1970 and Maryland in 1971 first adopted the brain-based definitions of death based upon the recommendations made a few years earlier by the Harvard Ad Hoc Committee on the Definition of Death. Because of the important effects pronouncement of death has, the decade after Kansas and Maryland embraced this criterion was filled with philosophical debate, for the question of when to treat a person as dead was not amenable to scientific methods for resolution. In 1980 the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research took up the question and published its report in 1981, endorsing what is known as the "whole-brain-oriented" definition of brain death. This definition has been adopted throughout the United States as well as in most countries around the world.

Much more controversial has been the debate surrounding the ethical issues related to how we approach people who do not meet the 1968 Harvard brain death criteria, for example, patients with brainstem reflexes but no higher brain function, described as being in a persistent vegetative state. Karen Ann Quinlan was at the center of the most famous case, which was tested in the New Jersey Supreme Court in 1976. This 21-year-old woman experienced respiratory arrest after consuming an overdose of tranquilizers and alcohol. Though she would never regain consciousness, she was stabilized on a ventilator. Her father wanted to act as guardian and remove the ventilator, knowing that this would result in her death. Quinlan's physician disagreed, and a lower court sided with the physician. The New Jersey Supreme Court said that the father could choose which physician he wanted for his daughter, allowing him therefore to choose a physician who would be willing to withdraw the ventilator. It was in this case that the court asked for input from an ethics committee. The Quinlan case thus brought about two important events: (1) rejection of the medical profession as having the authority to decide issues such as this, and (2) an advance in the development of hospital ethics committees charged with guiding decisions when medical staff and families are not in agreement.

The presidential commission that addressed the definition of death turned—in part because of cases like Karen Quinlan's—to questions about foregoing life-sustaining treatment. The report that emerged in 1983 emphasized the importance of voluntary choice of the patient to refuse life-sustaining treatment. The commission embraced the idea that when people are not competent to make such decisions, or else are competent but do not make their wishes known before losing competence, surrogate decision makers, generally from the patient's family, could decide such issues in the best interest of the patient. They supported the role of ethics committees in these decisions, though only a court can override the decision of a surrogate.

A number of other legal cases—such as that of Nancy Beth Cruzan in 1990, in which nutrition and hydration delivered via gastrostomy was removed after long legal controversy ultimately involving the U.S. Supreme Court—established the right to refuse ventilators, nutrition delivered via feeding tube, and other life-sustaining therapies that, in many cases, are identified not as extending meaningful life but rather as extending either the dying process or suffering.

Physician-Assisted Suicide

Perhaps the most difficult recent ethical controversy concerns physician-assisted suicide (PAS).

The issue was made prominent by media response to the efforts of Jack Kevorkian, a pathologist who openly participated in PAS. But he often did so without having any personal relationship with the patient—a fact that many found troubling. In contrast to this approach Timothy Quill assisted his patient Diane, who desired some independence and control and had a form of cancer that was 75% fatal, in the context of a long-standing relationship. In the United States, Oregon passed the Death with Dignity Act in 1997 allowing PAS. The past decade has not seen widespread embrace of Oregon's approach, and the issue continues to be debated. PAS generally involves making the means of death available to a patient—whether this means the use of the devices Dr. Kevorkian used or giving a prescription for lethal doses of medication as Dr. Quill did. A further distinction is drawn between making the means of death available and being an active agent in the death of a patient, an event in which a medical caregiver administers the lethal dose of medication, for example. Whereas in the United States precedent was set for PAS in Oregon, in the international arena precedent has been set for active involvement of physicians in euthanasia. In the past 20 years the Netherlands has opened the way for active voluntary euthanasia. The debate about such involvement of physicians often returns to the codes of medical ethics: How can a physician who is charged with care of the patient also kill the patient, no matter what the circumstance? And if active euthanasia is allowed in one circumstance, what is to stop it in other circumstances? If active euthanasia is allowed for intractable physical pain, what about intractable psychic pain? And does the disease process causing the pain have to be incurable? What if there is a 10% chance that the process can be cured in the next year? What about 5%? And what if we have to wait 3 years to find out the ultimate result? This debate is grounded in the history of bioethics and will form a significant part of its future.

Whether we are talking of medical interventions with the aim of cure, comfort, or control of one's destiny, there are two questions that must always be asked: What can be done next? and What should be done next? The means for answering the first question is scientific. The means for answering the second question is often more philosophical, drawing on many sources of wisdom and insight that are not intrinsically scientific in their approach. History has taught us that scientific advances without ethical considerations can become horrific. Likewise, wisdom without scientific advances cannot further the effort to cure the sick. Medical science committed to ethical research offers the best possibility for continuing the advancement of cures for human disease accompanied by humane and ethical responses to the realities of human suffering and death.

Raymond Barfield

See also Brain Death; Death, Philosophical Perspectives; Defining and Conceptualizing Death; Euthanasia; Kübler-Ross's Stages of Dying

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Body Disposition

Body disposition is the act of dealing with a human body after death. Worldwide, people have found various ways to dispose of human corpses. Death confronts people with a corpse that unavoidably needs to be subjected to some sort of treatment. Humanity has treated dead bodies in accordance to culture, religion, family needs of the deceased, and the deceased's wishes. It seems to be impossible to accomplish the disposal of a corpse without ritual.

The emotions aroused by death are frequently used to explain the subsequent body disposition. One of these emotions is people's fear of a corpse. Throughout the world, attitudes to the decomposition of corpses vary greatly. Hertz gives three explanations for this variation in attitudes. The

first he mentions is the fear for bodily decay and the hygienic consequences. Some people think that corpses have to be disposed of as soon as possible to minimize health risk. In fact, most dead bodies do not form a real health hazard with the exception of cases of infectious diseases, like plague. The second reason for the variation of attitudes is the social status of the deceased. The intensity of emotions differs depending on the life a person has led and his or her social status. The third explanation is the connection of the dead body to the soul. Hertz explains that people fear the soul, because it is considered to remain with the living until the bodily decay is completed.

Despite the variety in body disposition, two universal ways to dispose of a human corpse are burial and cremation. Within burial and cremation practices, there is also a great diversity. For example, there is burial under ground, burial at sea, the exposure of a body to the open air, cremation on a pyre, and cremation through extreme heat. Whatever choice of body disposition, the process is dynamic. The chosen method of disposition does not need to be a final act. Someone can be exhumed after burial, and the remains can then be cremated. Furthermore, the ashes can be used in different ways too.

Besides cremation and burial, there are several alternative ways of body disposition, such as preservation of a body by embalming and mummification, the donation of a body to science, plastination (a preservation technique used for the exposition of human corpses), cryonics (the preservation of a body by deep freezing), and, very seldom, mortuary cannibalization.

Burial

The disposition of a human body by putting it into the ground, called inhumation, dates back to the dawn of human history. It is still the most practiced form of body disposition. Archaeological evidence from prehistoric times points to this oldest form of burial by covering the body with soil and stones, or by placing the body in a cave. In the first decade of the 21st century, inhumation is still a common way to dispose of the dead. People can use a coffin (a box to bury the dead in) and place a stone on the grave as a marker, a point of identification and memorial. Other people, like Muslims, use clean, white cloths in which to wrap the deceased before burial.

Depending on the religion of the deceased and his or her family, choices were made about the posture and location of the body. For example, ancient Egyptians were positioned facing toward the West; many Christians buried their dead close to sacred places and laid them on their back with the hands in a praying gesture; and Muslims laid their dead with their right side facing Mecca.

Throughout the world, in times of disaster and war, people have used mass graves to dispose of a large number of corpses—for example, after a natural disaster such as an earthquake and during the genocides of World War II, Bosnia, and Rwanda. As most of the bodies in a mass grave are unidentified, it is difficult to locate missing people or give a confirmation of their death to the family. Major stress can be caused by the fact that the bereaved have not had the opportunity to dispose of the body of the deceased according to their own notions and rituals.

An alternative way of burial is the disposition of a body at sea. Occasionally, this method is chosen for a practical reason, such as when someone dies on board of a ship at sea. The body is deposited into the so-called watery grave. Contrary to this unforeseen way of disposition at sea, burial in water can also be a chosen action. Vikings placed the corpses of their deceased in longships and set them adrift. Among islanders in the South Pacific, the dead were placed in a canoe and sent off at sea.

Another way of body disposition is the exposure of a corpse to weather conditions or scavenging animals. The Zoroastrians, adherents of the religion Zoroastrianism, who live mainly in India and Iran, used this kind of burial. They place the body of the dead on hills where they are left exposed to the climate and scavenging birds and animals. In Tibet this method is called "sky burial"; a corpse is cut into pieces before it is exposed to scavenging birds. Another example of exposure comes from the Solomon Islands where the body was placed on rocks to be scavenged by sharks at the time of rising tide.

Another way of body disposition is tree burial, the exposure of bodies in trees and platforms, which can be found among Native Americans, the Sioux. They dressed the dead in their best clothes, sewed them in a deerskin, and exposed them on a

platform in a tree. After a period of time the body was brought back and given a burial in soil. In the examples given, exposure was understood as a sign of respect and honor. However, throughout time, exposure of people, for example, by leaving them hanging on the gallows, developed a connotation of humiliation rather than a sign of respect and honor. It becomes clear that it depends on the social, cultural, and religious aspects what meanings are ascribed to the chosen way of human disposition.

Cremation

Cremation is the disposition of a body by burning the body down to ashes and bone fragments. As early as 1000 B.C.E., the Greek were using this method during war. The corpses of soldiers were incinerated on the battlefield, and the ashes were sent home. The Romans also used cremation as a way of human disposition. After cremation, they put the ashes in an urn and placed it in a columbarium, a special wall with niches. After Europe converted to Christianity, use of cremation decreased. Cremation and the Christian idea of the resurrection of the body were regarded as incompatible because a physical resurrection would not be possible after cremation. Cremation was used only to dispose of a large number of corpses in times of disasters or outbreaks of contagious diseases. In 1886, the Vatican prohibited Catholics to use cremation as a way of body disposition; the ban lasted until 1963. Cremation was revived in Europe in the 19th century but saw little use. Popularity of cremation in Europe rose at the end of the 20th century. Most current Christian denominations allow cremation. However, doctrines of Orthodox Judaism and Islam forbid the practice of cremation.

In contrast to the situation in Western countries, cremation has always been practiced in India, by both Hindus and Buddhists. Hindus believe that human disposition by cremation is the right way to release the soul from the body. According to Hindus, the best location to cross from this world to a new world is on the sacred river Ganges. The holy pilgrimage city Varanasi, sited on the banks of the Ganges, is considered particularly appropriate for cremation. On a daily basis, cremation takes place in this holy city at pyres on the banks of the river. Hindus also use the Ganges for the immersion of ashes that were cremated elsewhere.

In North America and Europe, instead of an open fire, a cremation retort is used, a chamber where the body is transformed into bone fragments and ashes through extreme heat. Sometimes, the remains are put into a mill, which grinds the remains into white ashes. In many countries, it is illegal to burn more than one body at a time in the cremation retort. Each country has its own regulations for the scattering of ashes. Countries like the Netherlands and the United Kingdom return the ashes to the bereaved. They can decide the final destination of the ashes, whether they are scattered at sea, in the woods, or in a garden; or whether they are stored in an urn, buried at a cemetery, placed in a columbarium, or processed in mourning jewelry. The options are manifold.

Alternative Ways of Body Disposition

Besides burial and cremation, people can choose other methods of body disposition. In this section, the following alternative options are discussed: (a) embalming and mummification, (b) body donation to science, (c) plastination, (d) cryonics, and (e) mortuary cannibalism.

Embalming is a technique used to preserve a body by postponing the decomposition process. While modern embalming postpones the decomposition process only for a few weeks, mummification is intended to be permanent. A body can either be permanently preserved through mummification due to natural conditions, such as being trapped in clay or ice, or it can be preserved through human intervention. One of the earliest forms of mummification by human intervention is found among the Chinchorro of Chile. Archaeological findings of their mummies date back to 5000 B.C.E. Well known are the mummies of the ancient Egyptians and the pyramids built to protect them. Essential parts of the mummification process were the removal of the brain and the internal organs and the covering of the body in natron, a mineral used to dehydrate the body. Finally, the body was rapped in bandages and placed in a special body container, a sarcophagus. Even in the 20th century, people were mummified. The mummy of Lenin is still on public display in an elaborate tomb in Moscow.

Embalming is a more contemporary practice than mummification. Modern embalming is not

intended as permanent preservation. It aims particularly on sanitation, preservation, and presentation. It is a common practice in the United States, which became popular during the American Civil War when the need emerged to bring soldiers who died on the battlefield home. Modern embalming involves the injection of chemicals directly into the body and the appliance of cosmetics to the body. In the United States, embalming is used mostly for the viewing or visitation of the body before the final body disposition, to improve the visual appearance of the deceased, and to stop the bodily decay temporarily.

Body donation to science is an alternative way of body disposition that entails the donation of a body to an anatomical center. The donation of a body to science is a strictly voluntary act today, but in the past this was different. Cadavers of executed criminals, or bodies robbed from graves, were used frequently. The Dutch artist Rembrandt van Rijn painted *The Anatomical Lesson From Dr. Nicolaas Tulp* (1632) picturing an anatomy lesson in Amsterdam where the body of an executed criminal was used. It was regarded an additional punishment for the criminal to be dissected in public. A special type of public theater was built, called *Theatrum Anatomicum,* for public demonstration of dissections. Dissection takes place in an anatomical center that uses dead bodies for scientific research and education of human anatomy. If people decide to donate their bodies, they have to arrange this before they die. It is only by personal approval, written down in a signed contract between an anatomical center and potential donors, that people can donate their bodies. Throughout the world, each center has its own rules and formal procedures. Anatomical centers apply different preservation methods to preserve the tissue. This is done by inserting a cocktail of chemicals in the body or by freezing the corpse. Both methods stop the process of decay. Embalmed bodies are used mostly for education of students and frozen bodies for the training of surgeons. Defrosted bodies approximate living bodies better than embalmed bodies do and, therefore, are often used for the training of surgeons. When the bodies or the body parts are of no further use to the anatomical center, they are disposed of, either by cremation or burial.

Another way to dispose of a body is the donation of a body for plastination. Plastination is a preservation technique invented by Gunther von Hagen in 1977 in Heidelberg, Germany. This technique consists of replacing the natural body fluids with a plastic to preserve the tissue, which makes it possible to display the body in any desired position. In contrast to embalmed bodies, which are wet, plastinated bodies are dry and odorless, which makes them suitable for exhibition. The technique preserves the body for an indefinite period of time. The first exhibition with plastinated bodies was *Body Worlds* from von Hagen in Japan in 1995. Body Worlds has been traveling through the world ever since. It is comparable to the exhibition from Roy Glover called *Bodies*, which opened in Florida in 2005. Both have attracted millions of visitors, and both have created controversy. Questions focused on whether the body donors gave their consent and whether the display of the bodies was ethically sound.

Cryonics is the preservation of a human body by cooling the body down to stop physical decay. Cryonic supporters hope that in the future, advanced technology will be able to revive their bodies after death. They believe that the human identity is stored in the brain and, therefore, by conserving the brain structure people should be able to conserve their identity.

The idea to deep-freeze people was developed by the physics teacher Robert Ettinger, who founded the first cryonic organization, the Cryonics Institute, in 1976. The first person to be frozen was Dr. James Bedford, who is still stored today. This is not the case with all the bodies that have been preserved in the early days of cryonics. Due to financial problems of certain organizations, some bodies thawed. There are still two organizations for cryonics, both located in the United States. As of October 2008 the Alcor Life Extension Foundation in Arizona is storing 84 bodies, and the Cryonics Institute in Michigan, as of December 2008, is storing 91 bodies.

There are several methods to deep-freeze a body. The first method is to cool the body down to –196 °C in liquid nitrogen. However, this freezing process will damage the body severely; this damage is irreversible. A newer technique that has been developed to prevent the damage caused by the freezing process is called vitrification. The damage of the freezing is reduced by replacing water in the body with protective chemicals. This

technique can be used only for single organs and is, therefore, only used for the preservation of heads, called neuropreservation. In the Alcor Institute, people can opt to store their head only from which the brains are treated with the superior technique of vitrification, or they can choose to store their whole body with the more expensive but inferior method of deep freezing.

Cannibalism, also called anthropophagi, is the consumption of human body (parts) and can be considered, in a way, as a means of body disposition. In most cases, mortuary cannibalism concerns only the consumption of small body parts. The Berewan of Borneo prepared rice wine with the body liquids from the process of bodily decay, and the Amahuaco Indians of Peru drank a mix of cremated body remains with corn. In other cases, the mortuary ritual consisted of the consumption of the whole body. An example is the former mortuary rite of the Wari in Brazil. They practiced both the consumption of people outside their group, exocannibalism, as well as the consumption of their own people, endocannibalism. In the first case the focus of the rite was on humiliation and disrespect, whereas in the second case the focus was on respect and honor for the deceased. The occurrence of another form of mortuary cannibalism emerged in times of disaster, during war, or in exceptional cases of an airplane crash. In these cases, mortuary cannibalism was used as a last resort.

Sophie Bolt

See also Burial at Sea; Burial Laws; Cannibalism; Columbarium; Cremation; Cryonics; Embalming; Mummies of Ancient Egypt; Mummification, Contemporary

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Body Farms

A body farm is a research center where scientists study the human decomposition process. These facilities provide an environment whereby death and decay can be scientifically examined by replicating various settings. Body farms are an important component to better understanding the human decay process and how particular environments may affect the deceased's body. For example, scientists may reenact a murder victim left in a body of water for days prior to discovery or a victim burned posthumously. By studying the process by which bodies decompose when left to the elements, it is possible to accurately determine the postmortem interval in real time and recover any evidence of foul play. Thus, the data collected at body farms provide crime scene investigation teams and forensic anthropologists with important information regarding decomposition and proper techniques for collecting evidence from a victim's remains and the surrounding crime scene area. Because bringing a perpetrator to justice often requires that investigators place the criminal at the scene, the body farm staff are primarily interested in accurately determining the time of death based upon the state of the body upon discovery.

The first body farm was established in 1981 by Dr. William Bass, a forensic anthropologist at the University of Tennessee, Knoxville. Located on a 2.5-acre plot of land behind the University of Tennessee's Medical Center, "the Body Farm," as it is known around the world, is a fenced-in wooded site where Bass, now retired, and his graduate students place dozens of bodies and carefully record the rate of decomposition and the bacteria and insect activity for each of the death

scenarios. Once it becomes skeletonized, the staff then removes the remains and stores the bones for further research. Each body is systematically labeled with a set of numbers that corresponds with the deceased's arrival at the laboratory. For example, the fifth body donated in 1990 would thereafter be referred to as "5–90," even after skeletonization has occurred, in an effort to protect the identity of the donors. Bodies used for study at the University of Tennessee's body farm come from two sources. Staff members either take possession of unclaimed bodies left at the state medical examiner's office or, alternatively, people make arrangements prior to their death to donate their bodies. Each year between 30 and 50 people apply to donate their remains to Tennessee's body farm.

The body farm founder was a forensic anthropologist. Along with his role in founding the University of Kentucky's Forensic Anthropology Center in 1971, Dr. Bass served as a technical expert for many local and federal investigations. Body farms have now become an important tool for criminal investigators and lawyers because, prior to 1971, no one could determine with any certainty if a decomposed body was indeed a crime victim if there wasn't a bullet hole or other obvious evidence of struggle. Bass and his research staff have collected hundreds of remains, most of which have been left to skeletonize naturally after being exposed to the elements. This database of information is available to law enforcement and has allowed investigation teams to systematically compare their case to remains found in similar situations. The body farm's ability to re-create the decomposition process in a controlled environment has aided many criminal investigations and helped scientifically determine whether or not a body was indeed a victim.

Along with his scientific and academic contributions, Bass coauthored a number of books with journalist Jon Jefferson. Writing under the name Jefferson Bass, the two men have published two nonfiction books about the body farm, *Death's Acre* (2003) and *Beyond the Body Farm* (2007), as well as a fictional series about the body farm, including the titles *Carved in Bone* (2006) and *The Devil's Bones* (2008). The scientific work conducted at the body farm was also the inspiration for crime novelist Patricia Cornwell's 1994 best-selling book *The Body Farm*.

Along with the University of Tennessee's body farm, there are currently two other facilities in the United States. The second to open, Western Carolina University's body farm is affiliated with the Western Carolina University's forensic anthropology lab. This farm has the capability to hold six bodies in a facility approximately the size of a single car garage. This lab was opened in 2007 to better examine how the mountainous terrain of western North Carolina impacts human decomposition. The third and largest U.S. body farm opened for operation in 2008 at the University of Texas–San Marcos. This lab is nearly double the size of the Knoxville, Tennessee, farm.

Caitlin E. Slodden

See also Burial Laws; Decomposition; Forensic Science; Medical Examiner; Putrefaction Research

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Brain Death

It is commonly accepted within the medical profession that a person is dead when his or her brain is dead, an understanding that has largely supplanted earlier cardiopulmonary criteria for death. This definition evolved in the context of common use of mechanical ventilation, which allowed the artificial maintenance of cardiac and pulmonary integrity even after the patient's brain no longer functioned. The fact that patients without consciousness, brain-stem reflexes, or measurable electrical activity in their brains can be sustained for long periods of time with mechanical ventilation led a committee at Harvard Medical School

to address the issue of brain death in 1968. This committee defined brain death as a lack of responsiveness, movement, breathing, and brain-stem reflexes in the context of coma for which a cause has been identified, a state known as whole brain death (WBD). In the wake of the Karen Ann Quinlan controversy in 1976, many states worked to formally establish brain death as an acceptable criterion for death. Formal guidelines were published in 1981 by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. These recommendations included the use of confirmatory tests to reduce the length of required observation, ruling out shock before diagnosing brain death, and allowing a 24-hour observation period in cases of anoxic brain damage. After the guidelines were published, a number of individual states developed specific requirements, such as the need for two physicians to confirm brain death, permission for registered nurses to declare death with subsequent confirmation by a physician, and in some cases requirements that specific religious objections be honored.

In order to offer evidence-based practice parameters that might allow a more consistent approach to diagnosing brain death, the American Academy of Neurology published a report describing various clinical tools that might be used to establish brain death, including a description of apnea testing. Such guidelines are important because though the ideal might be for an experienced neurologist or neurosurgeon to evaluate patients, many smaller communities might not have access to such a medical professional. Several elements are required for the diagnosis. The absence of brain-stem reflexes must be documented. Brain-stem reflexes include response of pupils to light, the corneal reflex, the gag reflex, coughing with suctioning, sucking/rooting reflexes, and eye movement in the direction of the tympanic membrane stimulated with cold water after the head has been tilted 30 degrees (cold caloric stimulation). Likewise apnea must be documented.

Apnea is documented by disconnecting a patient from a ventilator and watching for breathing efforts as arterial carbon dioxide is monitored. It is defined as no respiratory effort at a partial pressure of carbon dioxide of 60 mm Hg or 20 mm Hg higher than the normal baseline. During apnea testing, the patient continues to be oxygenated. Coma is documented by absence of motor responses to painful stimuli, such as pressing on the nail bed of a finger or the supraorbital nerve above the eye socket. Computed tomographic scanning is important for determining the cause of brain death, though it does not replace careful examination. Similar guidelines were published in Canada in 2000 by the Canadian Neurocritical Care Group.

Confirmatory tests are available; these include transcranial Doppler ultrasonography, electroencephalography, cerebral angiography, and cerebral scintigraphy. These are most often used with child patients. For babies that are 2 months old or younger, two confirmatory tests are recommended, and for children between 2 months and 1 year old, one confirmatory test is recommended. For people over the age of 1 year, confirmatory tests are optional. In 1987 the American Academy of Pediatrics Task Force for the Determination of Brain Death in Children offered guidelines for brain death in children. Like the broader guidelines, these include coma, apnea, absence of brain-stem function, absence of movement, and no confounding circumstances such as hypothermia. However, they add that the clinical criteria are not useful in cases of infants under the age of 7 days, though they are useful with confirmatory testing in older babies. The application of strict criteria to young patients has not been uniformly accepted because of the lack of data about the ability of very young children to survive severe brain insults (e.g., through prebirth hypoxia), and the ethical concern that if such guidelines become standard despite the absence of data, pressure for such things as organ donation might unduly influence the recommendations of pediatricians attending to patients and families at the bedside.

Variations and Challenges

Though most countries have practice guidelines for brain death, there are variations internationally. For example, confirmatory tests are optional in many Central and South American countries while they are required in many European countries. Though practice guidelines have been developed in some African countries, including South Africa, many African countries do not have such guidelines. Some countries, such as Iran, Indonesia,

and Bangladesh, require that three people confirm the diagnosis of brain death. Other countries require two physicians but exclude the treating physician from the assessment.

In addition to international variations there are sometimes religious objections to the use of brain death as a criterion for death, though most religious denominations accept the criterion of brain death. For example, in the orthodox Jewish tradition, if the heart is functioning and the blood is circulating, even if the brain is not functioning, death has not occurred, though this does not necessarily mean that life must be prolonged artificially. Though in the Council of Islamic Jurisprudence held in Amman, Jordan, in 1986 brain death was accepted, and in the Third International Conference of Islamic Jurists brain death was equated with death, there has still been debate among Islamic scholars. But the issue of organ transplantation continues to spark debate about brain death, and most Islamic scholars now accept brain death as a religiously permissible definition of death. In Catholicism Pope Pius XII said that "it is for the doctor to give a clear and precise definition of death and of the moment of death," which many have taken as sufficient justification for the medical community's embracing of the brain death criterion. However, there continues to be debate as in a 2005 meeting at the Pontifical Academy of Sciences, where a subgroup concluded that diagnosis of death by neurological criteria alone is theory, not scientific fact, and is not sufficient to overcome the presumption of life.

The WBD criterion has come under critical scrutiny from other quarters as well. Some have argued that the clinical tests used to diagnose WBD are insufficient to prove that all critical brain functions have ceased. Parts of brain function are not tested—hypothalamic function, for example, which is critical for neurohormonal regulation and is an important part of the integrative function of the brain. Furthermore, there are some important functions of an organism that are not controlled by the brain or not controlled by the portions of the brain tested in an examination to determine WBD (such as energy balance, wound healing, immune responses to infection, and gestation of a fetus) that are uncharacteristic of the dead. From this perspective, WBD is not seen as death but rather as a severe disablement that frequently predicts death (understood as a loss of biologically integrated activity). Often such critics advocate a new definition of death that is not centered on biologically integrated functions of an organism, thus avoiding the alleged incoherence in equating WBD with death.

Brain Death and Organ Donation

One of the most important corollary issues related to brain death is the issue of organ donation. The number of cadaveric donors of organs fails to keep pace with the number of patients awaiting organs for transplant. Among the several important steps that allow a potential donor to become an actual donor, rapid and accurate determination of brain death is central. Physiological deterioration is common after brain death. Inefficient determination can lead to loss of valuable organs through delays that allow profound hemodynamic (hypotension following from low fluid volume, blood loss, or diabetes insipidus) and metabolic abnormalities to occur, damaging the organs. It is estimated that because of such events, which occur while waiting for a formal declaration of brain death, 15% to 25% of potential donors are lost. These are the sorts of cases in which use of a confirmatory test such as a nuclear brain flow scan can confirm brain death quickly after the initial clinical examination. In this way the time to declaration of brain death can be reduced and the likelihood that a potential donor can become an actual donor is increased. In addition to speeding the time to diagnosis, more organs might be salvaged by continuing to aggressively treat patients with severe brain injury in order to minimize adverse physiological changes prior to determination of brain death. These issues continue to be addressed through education and policy development.

Brain Death and False Positives

Inaccurate determination of brain death can lead to ethically inappropriate donation. There are a number of conditions that can mimic brain death. Hypothermia and drug intoxication are two that are addressed in the criteria for diagnosing brain death. In potentially reversible severe hypothermia in which the core temperature drops below 28°C, even brain-stem reflexes disappear. Excessive ingestion of drugs such as barbiturates can lead to

loss of some brain-stem reflexes. Many drugs can be detected by toxicology screen. Unfortunately some metabolites of drugs such as the opioid Fentanyl cannot be detected by routine screening tests and may require special tests. When there is suspicion of an undetected sedating substance, in the absence of a clear confirmatory test longer observation is generally necessary.

Another entity that can mimic brain death is "locked-in syndrome." This syndrome is often caused by an embolus to the basilar artery and leads to an inability to move the limbs, grimace, or swallow. Likewise the reversible Guillain-Barre syndrome (which is an ascending paralysis involving all peripheral and cranial nerves evolving over several days) can be mistaken for brain death, and in such cases the history is crucial for avoiding the mistake. Other substances such as diethyl organophosphorus insecticides can cause syndromes mimicking brain death, and because these organophosphates are absorbed into fat, their release can be delayed so that the signs mistaken for brain death do not show up until days after the ingestion.

In all of these cases, good physical examination must be coupled with good history taking to avoid making serious mistakes. Here too, use of confirmatory tests such as multimodality evoked potentials cannot only help to avoid delay in diagnosis of brain death but can also avoid errors in diagnosing brain death that might lead to unfortunate consequences.

Raymond Barfield

See also Defining and Conceptualizing Death; Life Support Systems and Life-Extending Technologies; Medicalization of Death and Dying; Organ and Tissue Donation and Transplantation

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Buddhist Beliefs and Traditions

A dead body was one of the four sights that a young prince named Siddhartha saw when he ventured outside the palace walls. Encountering sickness, old age, and death for the first time forced the prince to confront the sufferings and impermanence of life. The fourth encounter, the sight of a serene mendicant, pointed up an alternative path to untangle the mysteries of life and death. These experiences caused the young prince to abandon a life of comfort and luxury and to embark on a journey to seek the meaning of life. As legend has it, 6 years later he achieved a great awakening. He discovered that all sentient beings are afflicted by *dukkha* (suffering and dissatisfaction), that the causes of *dukkha* are discernible, that an end to *dukkha* is possible, and that there is a path to attain liberation from *dukkha*. Having awakened to these "four noble truths," Siddhartha became a Buddha, an awakened one. Known as Buddha Sakyamuni, he is said to have given teachings for 45 years all over northern India to guide people out of suffering. At the age of 82, he died, starkly demonstrating the impermanence of the body. The physical death of the Awakened One was his final teaching: that all living beings are subject to disintegration.

Impermanence, Old Age, and Death

During the many years that he taught, the Buddha often returned to the themes of impermanence, old age, and death. He recommended contemplation at charnel grounds as a way to gain realization of these realities of life. Seeing the corpses of the dead leads to insight and renunciation. Bodies that were once lovely and vibrant are now bloated and grotesque. Everything that comes into being eventually disintegrates, be it molecules or entire world systems. Contemplation on the inevitability of death is a reminder of the fleeting nature of life and the limited time we each have left for achieving liberation from perpetual cycles of death and rebirth. It serves as an incentive to renounce frivolous worldly activities and strive to cultivate wholesome actions of body, speech, and mind. Reflecting on the reality that death is inescapable

impels us to pay close attention to things "as they really are" and not get lulled into destructive, escapist, or meaningless activities. Coupled with an understanding of *karma* ("actions," the law of cause and effect) and rebirth, reflection on death engenders insight into the illusory, transient nature of sense pleasures. Recollecting that death is certain but the time of death is uncertain became a central theme of Buddhist meditation.

The Buddha's teachings on death and impermanence are reminders of the brevity of the human life span and the value of living a meaningful life to create the conditions for liberation. No matter how rich, famous, or accomplished a person may be, death is the inevitable conclusion of life. A realization that death is unavoidable is especially significant within the framework of rebirth, a widespread South Asian belief. In this framework, sentient beings do not live just once, but take rebirth in a variety of life forms, in accordance with their own actions (*karma*). Throughout many lifetimes—as a god, demi-god, human being, animal, hungry ghost, and hell being—they experience numerous sufferings and dissatisfactions in seemingly endless cycles of birth and death (*samsara*). Rebirth in the human realm is regarded as a precious opportunity. In contrast to other states of existence, human beings experience both pleasure and pain and have the intelligence to understand that these experiences are the consequences of actions they created in previous lifetimes. Human beings are uniquely capable of understanding the transience of their lives and the benefit of using life wisely for mental cultivation. A realization of the nature of death and impermanence is therefore critical for inspiring the impulse and determination to freeing oneself from repeated suffering and rebirth. The goal of the Buddhist path and the purpose of life is to become free from the cycle of birth, death, and rebirth and achieve the state of liberation (*nirvana*), or "deathlessness."

The Nature and Process of Dying

Although death comes to plant life and all compounded phenomena, Buddhists focus their attention on sentient beings, that is, beings with consciousness. Consciousness is distinguished from matter and is also subject to the law of cause and effect. Consciousness is impermanent by nature, arising and perishing from moment to moment. Each sentient being possesses an individuated stream of consciousness that continues from beginningless time until the moment of awakening. Through meditation and various methods of mental cultivation, it is believed that sentient beings are able to purify their mindstreams of afflictive emotions (*klesa*s) such as greed, hatred, and ignorance. The root afflictions spawn a host of other mental defilements and conflicting emotions, such as pride, jealousy, fear, and attachment, which give rise to unskillful actions. By extinguishing the mental afflictions, the root causes of unwholesome actions, such as killing, stealing, lying, and sexual misconduct, are eliminated and a state of mental clarity or awakening is achieved. When one is able to purify the mind of mental afflictions, there is no longer any impulse to create unwholesome actions and, by not adding more fuel to the flames, it becomes possible to free oneself from the tedious cycle of rebirth.

Philosophically, Buddhists do not understand death as simply the end point of one lifetime. Death also connotes the disintegration of electrons and constructs and world systems. All compounded phenomena are characterized by impermanence (*anitya*), arising and perishing from moment to moment. Even things that appear to be solid are, upon closer examination, composed of ever-changing particles. Human life is fleeting in the sense that all human beings will eventually die, but also in the sense that the cells of their bodies are in a constant state of change, with their constituent elements continuously coming into being and disintegrating. It can be argued that human beings begin dying from the moment they are born, with the cells of their bodies and the thoughts in their minds undergoing a series of emergences and small deaths all along the way. From this perspective, the human organism is subject to continual evolution and disintegration from the start of a lifetime and continues to decompose until the end. Insight into the workings of this process acts as an incentive to achieve liberation and thereby fulfill the purpose of human life.

The disintegration of the body into its natural elements is just one aspect of the experience of dying, however. Buddhists also seek to understand death from a psychological perspective. For example, fear, denial, and many other anxieties are said

to be aroused by the thought of one's own demise or disappearance. Based on the misconception that there exists some inherent or enduring essence to our self, we cling to our possessions, loved ones, identities, and life itself. The stronger our attachment to this misconception, the more stress and misery we experience when things fall apart. The mistake is in impossibly assuming that things will stay the same. This is not a moral flaw, but simply ignorance. The wisdom that recognizes the impermanence of all things not only accords with our own experience but also serves as a coping mechanism, enabling us to deal with disappointment and loss, including the ultimate loss that occurs at death. By developing the wisdom that understands impermanence, the mind becomes free of clinging to illusions of permanence and clinging to the self. For most Buddhists, ensuring the quality of countless future lives is valued over the pleasures of this single, brief life.

Preparing for the Experience of Dying

Because there is no predicting the time of death, Buddhists believe that it is crucial to prepare for the experience of dying beforehand and not leave things to chance. Living a kind and ethical life and developing insight into death and impermanence are essential for ensuring that a person dies peacefully without regrets. Mental cultivation is prerequisite, because even living a good life and understanding the reality of death intellectually does not ensure that a person will be able to handle the experience of dying well. During a life review, unpleasant memories may surface that arouse intense emotions and distress that may act as obstacles to a smooth transition. Because the last moment of death gives rise to the moment thereafter, it is vitally important for a person to remain calm and mindful during the dying process. At this critical juncture, no distractions or disturbances by loved ones or medical staff should be allowed to hinder the person's passage to the next life. At that point, a highly trained practitioner may even be able to achieve liberation from cyclic existence (*samsara*), but the majority of Buddhists are concerned simply to avoid taking rebirth in an unfortunate state. Buddhist practice is regarded as the best means to ensure a positive outcome.

From a Buddhist perspective, the moment of death is arguably the most important moment of an ordinary person's lifetime. Because the final moment of consciousness in this life serves as the proximate cause of the next moment of consciousness after the death of the body, turbulent emotions such as fear, regret, and anger and negative mental impulses are thought to propel a being to an unpleasant state of rebirth. By contrast, the ability to maintain a calm and peaceful state of mind, free from ill will, desire, or other disturbing emotions, will help ensure a pleasant state of rebirth. The moment of death is therefore of critical importance. By practicing mindfulness in everyday living and cultivating wisdom and compassion throughout one's life, one becomes more adept at the skills needed to prepare for a peaceful transition. Through the process of mental cultivation, one awakens to a new, unencumbered state of consciousness or direct awareness. As an ancient adage puts it, Buddhist practice helps one sleep well and die without regrets.

All Buddhist schools agree that the elements of the physical body disintegrate at death, but interpretations of the transition of consciousness from one lifetime to another may differ. There is no belief in a soul or permanent self that migrates from life to life, so Buddhists need to provide some other explanation for the mechanics of rebirth. Given that the process of rebirth is intangible, it is typically explained by way of an analogy: One candle flame lights a second candle, yet nothing substantial passes between them. For this reason, Buddhists prefer to speak of "rebirth" or "reexistence" rather than "reincarnation." Some texts describe the momentary nature of consciousness and how each moment of consciousness gives rise to the next, from moment to moment, and from one lifetime or state of existence to the next.

Differences of opinion exist among Buddhists concerning the nature and duration of the process of rebirth. Some Buddhists, such as followers of the Theravada and Zen traditions, typically accept that rebirth (or, properly speaking, reconception) occurs immediately after death. Others, such as followers of the Tibetan tradition, believe that there may be an interval between the moment of death in one lifetime and the first moment of life in the next. In the case of a sudden accident, Tibetans believe that rebirth may occur immediately.

Ordinarily, however, there is an intermediate state between the moment of death in one lifetime and the moment of conception in the next life. Tibetan texts present detailed descriptions of this intermediate state, which is known as the *bardo*. According to such texts as the so-called *Tibetan Book of the Dead,* the incipient being (*gandharva*) has an opportunity to assume a new form every 7 days. By the end of a 49-day period, it necessarily "descends" into a new state of existence. The influence of this tradition is reflected in funeral rituals throughout East Asia and Vietnam, where meritorious activities are held every 7 days on behalf of the deceased, with a final service held on the 49th day.

All Buddhist practices are useful for cultivating the mind, but certain practices focus specifically on death. The practice of meditating in cemeteries and cremation grounds is recommended for helping cut through attachment to the body. The practice of meditating on one's own death helps cultivate a sense of urgency for one's practice. In many Thai Buddhist monasteries, a skeleton hung at the entrance serves as a reminder. Another practice is to contemplate that death is certain, but the time of death is uncertain, and at the time of death only one's spiritual practice will be of any benefit. Contemplating the inevitability of death engenders an awareness that no living being escapes the ultimate sentence. Contemplating that the time of death is uncertain awakens the realization that death can come at any time, whether a person is young or old. Contemplating the importance of spiritual practice at the time of death means recognizing that wealth, power, and worldly achievements are utterly useless at this critical juncture. Family and friends, although they ordinarily may be sources of comfort, may even be distractions or attachments that impede a smooth transition to the next life. Another useful practice is Tibetan meditation that leads one through the stages of the dying process and beyond.

Ultimately, all forms of Buddhist practice are regarded as beneficial ways to prepare for dying. Meditation practices such as single-pointed concentration (*samadhi*), calm abiding (*samatha*), and insight (*vipasyana*) are especially useful for maintaining mindfulness at the time of death. Meditations to develop patience act as antidotes to anger and frustration that may arise at the time of death and lead to an unfortunate rebirth. Meditations on loving kindness and compassion help ward off feelings of ill will or resentment and nurture a calm and peaceful state of mind. The practice of generosity—giving away all of one's earthly possessions—is likewise meritorious and helps reduce attachments that might bind one to this world. The recitation of *sutra*s, *mantra*s, and prayers is thought to accumulate merit that will be beneficial for maintaining equanimity and achieving an advantageous rebirth.

Dying in Buddhist Cultures

Buddhists in various cultures have developed a variety of practices that not only help them prepare for death and facilitate the dying process, but also help survivors cope with grief at the loss of a loved one. At funerals in Theravada Buddhist societies, for example, a verse from the *Aniccagatha* is recited to remind mourners that all conditioned things are subject to change, that their nature is to arise and perish, and that everything that arises will eventually cease, resulting in peace. In Burma and Bangladesh, a subsequent verse is a reminder that all beings of the past, present, and future are subject to death, including oneself. Another well-known verse is used to contemplate that nobody knows how long their life will be, what diseases they will contract, where they will die ("whether on land or at sea"), when they will die ("whether during the day or at night"), or where they will be born after death. Buddhists in the Tibetan cultural sphere recite Mahayana texts such as the *Heart of Wisdom Sutra* and perform rituals derived from the tantric tradition.

Funerary practices and attitudes toward death in Buddhist societies may reflect pre-Buddhist cultural influences. In the *bhasi* blessing ritual in Southeast Asian Buddhist countries, for example, strings are tied to mourners' wrists to help keep their multiple souls together, despite the Buddhist teaching on no-soul (*anatman*). In East Asian Buddhist societies, prayers are directed to Buddha Amitabha, who is believed to transport sincere devotees to his Sukhavati Pure Land, where enlightenment can be effortlessly achieved. This practice helps dying patients approach the end of life in a peaceful state of mind and also helps caregivers deal with the stresses of patient care and bereavement. Groups of Amitabha devotees visit the homes and hospital rooms of terminally ill patients

and chant the name of Amitabha around the clock. Devotees find meaning in reciting the name of Amitabha repeatedly during their lifetimes, but it is widely acknowledged that the real benefits of the practice accrue at death. In East Asia, Buddhist understandings of death and practices for commemorating the dead often incorporate other cultural influences, such as the Confucian practice of ancestor veneration. Buddhist temples in China, Korea, Taiwan, and Vietnam usually set aside a shrine room for memorial tablets where prayers are offered and the merit dedicated to the memory of deceased relations.

Tibetan Buddhists have preserved several unique practices related to death. The first is meditation upon one's own death, with specific contemplations at each stage of the dying process. The practitioner first reflects on the dissolution of the five elements (earth, water, fire, air, and ether) and five constituents of the person (body, feelings, recognitions, karmic formations, and consciousness) in sequence, then concentrates on the successively more subtle stages of the dissolution of consciousness. After dispassionately observing these stages of dissolution, one becomes aware of the "clear light of death." If one is able to realize the emptiness of this intensely bright light as being identical to the empty nature of one's own mind, it is possible to achieve perfect enlightenment at that moment. In another meditation practice called *phowa,* one directs the 72,000 winds of the body into the central psychic channel and consciously ejects them through the crown *chakra* to effect rebirth in the Pure Land of Amitabha. Once death occurs and a religious specialist ascertains that the consciousness of the deceased has left the body, the physical remains of the discarded corpse may be offered to birds and wild animals as a final virtuous act of generosity that is known as "sky burial."

Death as Opportunity

In the Buddhist worldview, death is not only inevitable, it is also a great opportunity. A dying person may achieve many realizations—of suffering (*dukkha*), impermanence (*anitya*), and the absence of an enduring self (*anatman*). Awareness of the sufferings of death may engender genuine compassion for the sufferings of others. Reflection on the ephemeral nature of living beings may stimulate the development of wisdom into the true, self-less nature of phenomena. Reflection on the kindness of others may engender feelings of loving kindness for all sentient beings. In these ways, instead of unpleasant feelings of regret, resentment, or helplessness, a person may transform the process of dying from a deeply painful and disturbing experience into a profoundly meaningful opportunity.

Buddhists also regard death as a meaningful opportunity for medical professionals, hospice personnel, and caregivers to gain a deeper understanding of the human condition by mindfully and respectfully caring for the dying. Not only can they develop insight into suffering, impermanence, and no-self, but they also have the opportunity to practice patience and loving kindness. Buddhists generally view palliative care favorably and the premature termination of life unfavorably. It is desirable to ease the suffering of terminally ill patients through all appropriate means, including medication for pain management, as long as these methods do not endanger the life of the patient. Developing the skills to skillfully alleviate physical, psychological, and spiritual pain is viewed as a rare opportunity to practice wisdom and compassion.

Buddhism and Bioethical Decision Making

Given the diversity of attitudes and cultural practices among the world's hundreds of millions of Buddhists, it is impossible to make definitive statements on bioethical issues. The Buddha had no access to modern medical technologies, and there are no universally recognized institutions to deliver position papers on the complex issues these technologies have spawned. The touchstone of Buddhist ethical reflection is to refrain from taking the life of any sentient being, especially a human being, and to refrain from harming that being in any way. Ethical decision making at the end of life is guided by these fundamental principles, based on *karma* and compassion (the wish to free all beings from suffering). For these reasons, although no rules are inviolable and decision making is ultimately the responsibility of individuals, it is believed that abortion, suicide, euthanasia, and assisted suicide are best avoided. In writing a living will or advance health care directive, there is no moral fault in refusing artificial

life support and dying a natural death. Taking someone off life support once it has begun is a more complicated issue. The merits of advanced technologies will be weighed differently by Buddhists throughout the world, whether in Japan, Mongolia, Laos, or Los Angeles, but decision making will be guided by a core of common ethical principles and similar understandings of life and death.

Karma Lekshe Tsomo

See also Ancestor Veneration, Japanese; Bereavement, Grief, and Mourning; Funerals and Funeralization in Cross-Cultural Perspective; Life Support Systems and Life-Extending Technologies; Palliative Care

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Burial, Paleolithic

The limited nature of the evidence from the Paleolithic, or Old Stone Age, a period beginning over 2.5 million years ago, poses a challenge to archaeologists. Funerary deposits seem to have been limited to cave sites; however, this may indicate more about how artifacts and ancient deposits survive than it does about the limits of cultural practice. During this period there were a number of destructive geoclimatic events, including ice ages, which may account for the absence of evidence since individual hominid species and early human populations may have numbered in the tens of thousands, not tens of millions. Cave sites may have survived continental ice sheets as they were sheltered, just as deeply buried deposits may have survived but are difficult to identify and more difficult still to excavate. Despite the limited and fragmentary nature of the archaeological record, it is evident that it is the Paleolithic that demonstrates first the emergence of human culture and a growing awareness, or at least representation, of human mortality.

Archaeologists have divided the Paleolithic into three phases: the Lower, Middle, and Upper Paleolithic. The Lower Paleolithic is the period from around 2.5 million to about 100,000 years ago and is characterized by the emergence of the *Homo* genus and the development of stone tools. The Middle Paleolithic is roughly the period 300,000 to 30,000 years ago, although there are regional variations in this dating. This middle period is characterized by the emergence of modern man, *Homo sapiens,* between 130,000 and 200,000 years ago. *Homo neanderthalensis* occupied most of Europe during the Middle Paleolithic, and there is debate about the nature of the interaction between these two species. The Upper Paleolithic is often considered to start around 40,000 to 30,000 and have lasted to about 10,000 years ago. It is a period characterized by the survival of more significant numbers of cultural artifacts and art, such as cave painting, campsites, and Venus figurines, as well as advances in the technology of flint tools seen in the utilization of blades rather than choppers or flakes, which may have had a specific function. Bone and antler artifacts such as harpoons also survive.

Lower Paleolithic

There is no evidence for a burial tradition in the Lower Paleolithic, but it is important to understand the development of humans as part of the development of a cultural or social awareness. The early hominids of this period had a more sophisticated social structure than chimpanzees, had larger brains, and made more elaborate stone tools. They seem to have developed a society

based on hunting and gathering and used stone tool technology based on flint choppers made from large pebbles. Little evidence from this period survives and that which does often consists of small collections of bones, collection of flint, or, very rarely, kill sites where stone tools and animal bones coexist in the same space.

Two possibly anthropomorphic figures may be associated with the Lower Paleolithic. The Venus of *Tan-Tan,* found in Morocco, is a small quartz object that might have represented a genderless figure and may have been painted in red ochre. The Venus of *Berekhat Ram,* Golan Heights, is a red stone object that, like the Venus of *Tan Tan*, seems to have been manipulated to resemble a human form. Much controversy surrounds both objects and the intentionality of their crude anthropomorphic shapes; however, they do seem to be altered by hominid hands and both date to over 250,000 years ago.

Although no constructed funerary deposits have been identified, artifact manipulation beyond simple tool manufacture and possibly bodily or spiritual representation start to emerge at the end of the Lower Paleolithic. However, a question remains about the exact nature of funerary treatment. A high proportion of later Lower Paleolithic skeletal remains exhibit signs of cut marks. Around 80 fossils from the cave of Gran Dolina, Atapuerca, had cut marks, and long bones had been split like the other animals. Both the sites of Bilzingsleben, Germany, and Bodo, Ethiopia, revealed *Homo* genus skeletal remains with cut marks across bones and the skull. If this is evidence of cannibalism, it is important to consider if this is a ritual treatment or prey-related cannibalism—food or funeral. Either way, it is a form of recognizable postmortem bodily treatment.

Middle Paleolithic

Greater amounts of material culture survive from the Middle Paleolithic, and there is indisputable evidence for intentional artistic behavior. Stone tools become smaller and may have been fit for specific purposes carried in kits or combinations. Both *Homo sapiens* and *Homo neanderthalensis* seem to exhibit evidence of postmortem bodily treatment. Like archaic *Homo sapiens, Homo neanderthalensis* seems to have been capable of basic verbal communication and used complex flint, bone, and other tools as part of kits. However, when it comes to funerary treatment, there seems to be some question about whether this hominid could have practiced its own form of burial ritual, thus demonstrating what has been regarded as a very human awareness of personal morality or whether it was simply copying early human behavior. Two of the most famous sites are those of La Chapelle-aux-Saints and Le Moustier, both in France. Moustier revealed a fully articulated skeleton buried crouched "as if asleep," and at La Chapelle-aux Saints, a similarly interred individual with articulated cow bones placed above the corpse was found. Perhaps the most striking inhumation is that of the Iraqi, Shanidar 4, grave. An adult male Neanderthal age between 30 and 40 had been placed in a fetal position. From on top of the skeleton, soil samples revealed evidence of ancient pollen. Yarrow, cornflower, bachelor's button, St. Barnaby's thistle, ragwort, grape hyacinth, joint pine, and hollyhock were identified—all plants with some medicinal properties. In the minimalistic interpretations of the late 1980s, scholars argued that all of the cases of Neanderthal burial could be put down to accident survival, simply crawling into a confined space to die. However, this failed to account for the intentionally cut graves and the deliberately medicinal nature of the floral assemblage found at Shanidar, one unlikely to have formed simply though the action of animals or the wind.

Modern human burial in the Middle Paleolithic is not dissimilar to that of the Neanderthals, and the inhumations at the cave site of Mugharet es-Skhul, Israel, contained the remains of four individuals purposefully arranged with flexed limbs. Inhumation 5 was interred with the jaw of a wild boar; inhumation 11 included the skull of a cow. Burials at Qafzeh, Israel, contain the remains of a fallow deer. It is the position of the burials that most clearly indicates human intervention. The Middle Paleolithic yields the placement of supine, crouched, and prone burials. However, the question is not just about bodily placement but also alteration, and there are a number of examples where the body was purposefully taken apart: at the spine as at Roc de Marsal, France, or buried with skull and body separated as at La Ferrassie, France. Despite the evidence of individual graves,

it is the whole assemblage that is most convincing when considering the intentional nature of burial in this ancient period. Both Neanderthals and anatomically modern humans demonstrate significant regional-, age-, and sex-related differentiation in their burial practice. Grave goods are fewer than in the Upper Paleolithic and consist of animal bones, flint points and scrapers, and occasionally shells or other stone objects.

Upper Paleolithic

With the burials from the last 30,000 years of this 2.5-million-year period, there can be no doubt that the humans of the Paleolithic recognized and responded to death. Upper Paleolithic burials were not only deliberate, they were accompanied by sophisticated material and culturally important remains. Perhaps the best preserved of these burials is from the site of Sunghir, near Moscow, where the burial of an adult male was identified along with thousands of ivory beads. Also at Sunghir was a double burial of two juveniles (one male, one female) who were buried with more than 10,000 ivory beads, mammoth ivory pins, discs and pendants, a belt of fox teeth, antler batons, a polished human femur containing red ochre, and a large ivory lance made from a straightened mammoth tusk. In another extraordinary burial site at Dolní Věstonice, Czech Republic, a woman was placed between two males; they all had red ochre on their heads and her groin. They were accompanied by tooth pendants, ivory beads, and shells. Another typical burial from this period is the red lady of Paviland Cave, Wales, where a skeleton (later identified as a man) discovered in a shallow grave showed extensive red ochre staining on the body and surrounding surface, along with pieces of jewelry made from mammoth ivory, sea shells, and a mammoth skull, which has been lost since the first excavation.

Burials from the Upper Paleolithic are more common than earlier ones, and some 50 remains exist from Italy alone. These burials have been identified as coming from two distinct phases of activity. During the first phase, most of the remains are of adult or juvenile males, some ochre was always found, and stones were often part of the structure of the grave. Bone and stone objects were usually present in the burial and were always positioned along the axis of the cave. In the second phase, ochre was found much less frequently as were grave goods; stones were not utilized in the structure of the cut; burials were found in a transverse position to the cave; and women and children were also identified. Upper Paleolithic burial practice shows elements of similarity across the Old World, but this should not be seen as a uniform tradition. Regional variations, as well as chronological transformations, were part of this burial practice just as they are in the material remains of an emerging cultural identity; indeed, by the end of the Paleolithic it is even possible that ethnically distinct groups had emerged.

Conclusion

In summary Paleolithic burial practice is evident, especially from the later part of the period. There is evidence of postmortem treatment in the Lower Paleolithic, but it is not clear if this was truly the beginnings of a funeral tradition. Modern Western attitudes may have difficulty seeing cannibalism on its own as an indication of an awareness of personal mortality. However, animals such as elephants are aware of each other's deaths, so possibly researchers are simply approaching the problems of mortuary awareness in the wrong way. The first evidence of a recognizable cultural expression of mortality appears in the Middle Paleolithic, and both anatomically modern man and Neanderthals were found in graves and caves and show a distinct amount of variation across gender and age. This suggests that these are deliberate, structured deposits even though it is not until the Upper Paleolithic that a large amount of recognizable material culture is identified in graves and regional, cultural, and possibly personal identities are evident in the burial tradition. Humans may have been aware of their own mortality for a million years but it is only in the last 50,000 to 100,000 years that they have chosen to express it in a culturally distinct form that survives in the archaeological record. The later burial assemblages are sometimes found accompanied by fragments of human remains, sometimes adopted or altered for specific uses. These objects might suggest that a tradition of disturbing the dead and incorporating the remains of the

deceased into the lives of the living may have been a more widespread tradition than burial practice and wider than can be witnessed in archaeological deposits.

Duncan Sayer

See also Death, Anthropological Perspectives; Funerals and Funeralization in Cross-Cultural Perspectives; Immortality; Mortuary Rites

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Burial at Sea

The broad definition of burial at sea encompasses deposition of the corpse in all bodies of water, including not only the sea but also rivers, lakes, and even small ponds. Water burial has been employed by numerous cultures over time, sometimes as a deliberate choice for the disposal of the dead and other times purely out of necessity. Although the rituals employed in burying a body in the water often mimic those on land, there are important differences due to the nature of the aquatic environment. This entry examines the need for proper burial rites at sea, discusses the wide divergence in cross-cultural attitudes toward water inhumation, explores the burial at sea service as a ritual of separation, and notes modern trends in disposing of bodies at sea.

The Need for Proper Burial

Despite the fact that many societies have employed water burial throughout history, cross-cultural comparison indicates that humans are wary of burial at sea unless the proper rites can be performed. Among the Tikopia of the South Pacific, for example, Firth recorded the belief that those who were lost at sea—and thus did not receive a proper funeral—would return to haunt their families, causing sickness or even death. In Tikopia society, religious specialists had the crucial job of contacting lost spirits to find out what had happened to them and where their bodies rested. Armed with this knowledge, the family could then perform a funeral and lay the spirit to rest. This belief is strikingly similar to Western mariners from the Age of Sail, whose stories and songs are replete with the spirits of those who died at sea. Although these ghosts, unlike those of the Tikopia, sometimes aided vessels instead of causing harm, mariners always feared them. The spirits of those buried in the water, like those who die unnatural or untimely deaths on land, are widely held to return unless proper burial rites are performed.

Attitudes Toward Water Burial

Cross-culturally, attitudes toward water inhumation vary from acceptable to undesirable. Some cultures view water as the proper place for the dead, whereas others see it only as a place of last resort or as the place to dispose of criminals or other social outcasts. The former attitude is probably best exemplified by the Hindu belief that the river Ganges is a sacred place that will take the dead to heaven. At the other end of the spectrum lies the idea of water as a convenient place for the elimination of unwanted items. Throughout history, humans have viewed water as a place to dispose of things that are no longer wanted or needed, including corpses. Lindenlauf's research, for example, highlights the similarity between the attitude of the ancient Greeks and modern garbage disposal practices. In both cases, water is seen as a "place of no return" in which unwanted things could be safely discarded.

In keeping with the idea of water as a place for the disposal of refuse, many societies have viewed the sea as the proper place to deposit the bodies of

those who are tainted in some way. The Andaman Islanders, for example, were known to throw the bodies of strangers or enemies into the sea with no burial rites whatsoever. Krause observed that the Tlingit peoples of Alaska did the same with slaves. In both of these cases, disposing of humans in this manner was not thought to generate restless spirits in the way described earlier. This seems to be because strangers, enemies, and slaves were not accorded status as members of the group. They were, in essence, not human. The "bog bodies," of prehistoric northern Europe, which exhibit signs of trauma and were often bound, may also be the bodies of criminals, enemies, or slaves disposed of in the water in a manner comparable to that practiced by the Andaman Islanders and Tlingit.

A similar practice held sway among the Chuuk culture of Truk, who consigned the corpses of infants who died in childbirth to the sea without funeral rites. To the Chuuk, this was acceptable because the infants had not yet become people. The Chuuk did the same thing to members of families who did not own land. When such people died, their bodies were simply thrown into the sea as well. In all of these cases, the key point is that the individuals concerned were not considered to be actual human beings. Thus, it was seen as appropriate to dispose of their corpses in water with no funeral ceremonies.

A similar idea occurs in some cultures that practice secondary burial. In some cases, the body is buried in the ground long enough for it to begin decomposing, then exhumed and the remaining flesh removed from the bones. The bones are cleaned and either given another funeral or retained for various ritual purposes. The decomposing flesh, however, is typically discarded without ceremony. Among cultures that practice water burial, such flesh is often simply cast into the sea. Like the bodies of enemies and slaves, the sea is seen as a proper place to deposit these parts that are not considered important and are no longer wanted.

During the Age of Sail, western seafarers held both positive and negative views toward burial at sea. On the one hand, the sea was seen as the proper resting place for sailors, because it was home to them in the same way that the land was home to farmers. This attitude may, however, have been a reaction to the necessity of sea burial rather than a full acceptance of it. Before the advent of embalming or refrigeration in the 19th century, it was not possible to keep cadavers aboard ship for long, and therefore most of those who died at sea were forced to be buried in it out of necessity. Although sailors came to view this as accepted practice, they were never entirely comfortable with it. This is shown by the fact that bodies were buried ashore if at all possible. When far out to sea, however, land burial was not an option, so sailors devised a burial rite to ensure the dead of a proper funeral.

Burial at Sea as a Ritual of Separation

Like all burial rites, deposition in water takes the form of a ritual of separation in which the deceased is symbolically removed from the world of the living and placed in the realm of the dead. It is important that rituals such as funerals be performed correctly; otherwise they will not have the desired effect. In the case of funerals, improper performance of the ritual means that the dead will not rest. Instead, they will return to haunt the living as ghosts, vampires, or other revenants. On land, funeral rites follow set patterns, and any deviation from accepted practice is seen as dangerous because it may lead to the return of the dead. During the Age of Sail, American and European seafarers adapted the funeral service used on land to shipboard.

However, one of the major problems with burying bodies at sea was that it was not possible to perform the ritual in the same way as was done on land. In particular, two critical elements were missing at sea. First, land funerals began with a procession from the deceased's house to the cemetery. This was more than just a formality. The journey, which was often done by a meandering route and involved numerous stops for prayer and songs, was meant to keep the dead spirit from being able to return and haunt its former home. Aboard ship, no funeral procession could be performed, so the spirit could not be separated far from the living.

The second major problem at sea involved sealing the dead inside the grave. On land, the earth shoveled into the grave provided both a symbolic and a real barrier between the living and the dead. In addition to providing a medium in which the corpse would be contained and deteriorate, earth shoveled onto the coffin also provided a symbolic barrier against the return of the deceased's spirit. Water, on the other hand, is fluid and thus provides

no secure barrier. Weights were employed to ensure that bodies dropped overboard would sink, but sailors had no way of knowing exactly where the corpse had come to rest. Moreover, a corpse resting on the seabed was not as trapped by a layer of earth as was one buried in a grave. Sailors were familiar with the way that the sea cast objects up on shore that had been deposited in its depths and knew that this could happen to the bodies of those buried at sea as well. Because of this, they seem never to have trusted the sea to keep the bodies of the dead that were buried in it. Instead, maritime literature from the Age of Sail reveals that sailors were always uneasy about those who had been buried at sea. Such dead frequently appear as ghosts in seafaring stories and songs. While many of these are no doubt fictional rather than factual, they reveal the uncertainty concerning water burial that existed in the minds of those who composed them.

Modern Burial at Sea

Modern burial at sea has changed much from the traditional model of a land-style funeral service transplanted aboard ship. Instead of burial at sea being almost exclusively a province of sailors, increasing numbers of people now view it as an attractive alternative to crowded cemeteries on land. In Western nations such as the United Kingdom and the United States, cremation is a popular alternative to burial, and the deceased's ashes are often scattered in a place that had meaning to the deceased or his or her family. Those with a connection to the sea often choose the water as the fitting place to scatter their loved one's ashes. Others who may not necessarily have had a connection to the sea during life are coming to view it as an ecologically friendly burial alternative. At least one company now offers a service whereby the ashes are incorporated into artificial reefs. This, like other forms of "green burial," reflects a modern ideal to be environmentally conscious and uses the burial as a way to help the environment.

Conclusions

Burial at sea has been practiced for thousands of years, in forms as diverse as the cultures that have used it. Several prominent trends emerge from a study of burial at sea. First, some cultures view burial in the water as undesirable and often restrict its use to those who are seen as outsiders or undesirables, such as enemies or slaves. Among seafarers, burial at sea came into use out of necessity: Sailors had to have some means to dispose of those who died aboard ship. Their solution was to adapt land-based funeral rites to the aquatic environment, but such attempts were never entirely satisfactory. In recent years, burial at sea has gone from being something done out of necessity to being seen as a desirable practice to promote responsible environmentalism. No doubt forms of burial at sea will continue to change over time to reflect changing views of humanity's relationship with the sea.

David J. Stewart

See also Accidental Death; Body Disposition; Funerals; Green Burials; Zombies, Revenants, Vampires, and Reanimated Corpses

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Burial Insurance

Burial insurance is a whole life insurance policy with a cash death benefit that can be used to pay

for expenses. Such expenses include burial plot, casket or urn, cremation, embalming, digging the grave, hearse, and grave marker. In the past, insurance premiums as low as 25 to 50 cents were popular among working-class American blue-collar workers and blacks, who held small amounts of disability and burial insurance and paid the premiums weekly or monthly through a funeral home or directly to an insurance agent (debit man) who collected premiums from policyholders at their place of employment or their home. In this area, many black Americans in the past were similar to the contemporary French and British, who tend to purchase small amounts of insurance for burial purposes. Low-cost burial insurance at $2 or $3 a week continues to be a significant investment for many low-income families and, more recently, the elderly.

Burial insurance is the final expense insurance, an expense that many people desire not to burden others with. Thus, burial insurance is a highly desired commodity in that it offers what some refer to as "peace of mind insurance," especially among older individuals. In the southern portion of the United States, older blacks held burial insurance in high esteem, with a sense of security and pride, because to have this form of insurance was to ensure the financial costs incurred at the time of death would not be passed on to others.

Burial insurance costs range from as low as $250 to more than $10,000. Of the five types of life insurance available, burial or funeral insurance is perhaps the most important, especially for low-income families. Burial insurance also is referred to as "pre-need insurance," but these two forms of insurance should not be considered to be the same. Burial insurance is whole life insurance with a death benefit in varying amounts. Pre-need insurance, on the other hand, is a prepayment of funeral arrangements in which all aspects of the process are predetermined and paid for in advance.

The History of Insurance

In 1759, the first American life insurance company was founded, and it was joined in 1770 by its first competitor. By 1800, the number of life insurance companies doubled in size to equal four. Thereafter, the growth of the industry was dynamic, inhibited only during extended periods of economic depression that was cause for the collapse of financial markets.

Burial or industrial insurance was first sold to British factory workers. In 1875, with the founding of the Prudential Friendly Society, burial insurance was introduced into the United States and soon became popular among black families in the Southeast. The American life insurance industry thrived, with sales of life insurance policies to middle-income and labor-intensive lower-income families. From 1927 onward, an industry movement toward professional development held important implications for the door-to-door insurance agent (debit man) who sold small burial policies to low-income families. This was especially true for that majority of agents who, it is stated, held a humanistic orientation toward clients in that they believed the lifeblood of life insurance industry was catering to the needs of families with more modest incomes. Burial insurance represented one of these needs.

Burial Insurance and the Debit Man

A debit is the sum of premiums payable within a stipulated time period (usually a week or month) by policyholders in an agent's geographic area. The term *debit* was frequently used to describe the geographic area and the premiums to be collected from the area's insurance policyholders.

Debit men actively pursued payment of a weekly or monthly debit premium charge for burial insurance and industrial accident insurance. Individual insurance policy debit accounts were carried on the books by insurance companies because many of their clients were low-income workers who often struggled to make these monthly debit payments; the debit man made house calls to encourage payment compliance.

The later entrance of blacks into the insurance arena as owners was prompted by a number of factors. The weekly visits of white agents to the homes of blacks to collect premiums (debits) were generally tolerated until the organization and entry of Negro companies into this field. The insults, abuses, and violations of the privacy of the homes of black policyholders by white agents, especially in the American South, are thought to have facilitated the creation of black-owned industrial life insurance companies.

Growth of a Minority Industry

Black life insurance companies grew out of the church relief societies of the 1787 to 1890 period and the Negro fraternal benevolent burial associations that flourished in the United States from 1865 to 1915. Consistent with the fact that blacks were primarily involved in an industrial labor-intensive marketplace, most of the insurance sold first through benevolent societies and later through black-owned insurance companies covered the areas of health and accident. In reality, this form of industrial insurance was intended to provide modest benefits for the disabled and a decent burial for the deceased.

By 1940 there were 46 Negro life insurance organizations located in 24 states and the District of Columbia. The rapid growth of industrial life and disability insurance among members of the black community can be attributed, in part, to the sensitivity of the black insurer in promptly making payments to claimants.

The importance of some amount of life or burial insurance, no matter how small the policy is worth, has held an attractive lure to almost all segments of the U.S. population. Indeed, it was through the determined efforts of individuals such as the lower-status "debit man," who serviced the needs of these low- to middle-income families, that this substantial portion of a vast industry was created and nurtured. Since 1983 yearly life insurance purchases have exceeded $1 trillion. With more than 21 million burial policies and $16 billion in force at the turn of the 21st century, burial insurance represents an important component of the insurance market.

Dennis L. Peck

See also Burial Laws; Economic Evaluation of Life; Inheritance; Life Insurance; Viatical Settlements

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Burial Laws

Unlike laws regulating the insurance industry, the legal profession, or matters of inheritance, burial laws found in the United States do not possess a common theme or thread of statutory logic. Each is different, and many are silent where others are detailed.

The burial laws first adopted in the United States reflect English common law and/or church rules and regulations governing church cemeteries in Great Britain and those for other European societies. Following such common law doctrine and based on practical experience, these early laws adopted by the various states addressed what needs may have been perceived. As burial laws evolved, state legislatures were, in most cases, reacting to specific and unique issues surrounding municipal, religious, and fraternal cemeteries found within the state. Model statutes to consider during the previous century were nearly nonexistent; thus hybrid legislation resulted.

Today, burial law can be as brief as a passing mention within several sections of state code or as highly detailed as to fill entire chapters of law in which state agencies (e.g., state cemetery boards) are created to regulate such laws. The pattern appears to be no pattern. Other than national cemeteries (veterans' cemeteries) and specific protections offered to Native American and historical burial grounds, very little exists in federal statute regulating cemeteries and burial practices.

The U.S. Geological Survey estimates there could be as many as 200,000 burial grounds in the United States; statistically, there are at least 100,000. The U.S. Geological Survey's estimate includes any and all burial grounds (sites), even those where just one or two burials may exist, for example, a sealed mine shaft with known accident victims who were never removed. Today's burial laws govern cemeteries of record, both active and inactive.

There are four major subjects found within today's burial laws: (1) cemetery land and issues related to such, (2) individual and family burial

rights and the nature thereof, (3) business regulation and exemption from such (i.e., religious organizations), and (4) jurisdictional authorities (i.e., coroners, taxing districts, etc.). With the evolution of the so-called modern cemetery and that of "before need (pre-need)" sales practices, new laws have been developed to protect trust funds and the rights of both the modern cemetery and its consumers.

Cemetery Land Law

Most burial law today recognizes the unique nature of cemetery land as it relates to land use and property taxes. Burial land often is exempt from property taxes and various types of regulatory fees. "Dedication" of cemetery lands for cemetery purposes only protects the continued use of cemetery land from generation to generation. Dedication in most cases is filed with a county or borough recording authority, and to remove such dedication requires extraordinary actions. In many cases, courts of competent jurisdiction are required to concur with dedication removals. Burial laws appear to recognize that changing societal values and needs must be balanced with the established values expressed at the time of dedication. Dedication in many cases can represent promises to consumers that might take a century to fulfill. For example, 100 acres of land is dedicated in 1890 for cemetery purposes. The cemetery in this case is cared for with proceeds from an endowment care fund that derives its capital from deposits made as individual graves are sold. To "fully fund" such an endowment, the fund expects all available space within the dedication to be eventually sold. But later, the operators of the cemetery see greater revenue opportunities in selling unsold grave space for a housing development, a prospect never envisioned 118 years earlier. Burial law that protects dedicated cemetery land addresses the fact that the unfilled sales volume will undercut fulfillment of the care fund, thus damaging society's promises made decades ago to now deceased individuals. Enter the courts or a state agency for competent jurisdiction pursuant to dedication removal procedures.

Burial laws today attempt to, in many cases, address the four different approaches found in the continued maintenance of cemeteries. Given the oversight needed and the nature of the maintaining organization, cemetery burial law can be simple or detailed. Some cemeteries are maintained by volunteer organizations that put together community days during which all interested parties are asked to pitch in with maintenance help. Burial law may address protection of the Good Samaritans helping out from the legal efforts of those who argue their family grave was desecrated by such volunteerism. Church and fraternal orders own and operate many cemeteries, maintaining the property through cemetery sales and the "collection plate" of their organizations. Burial laws often exempt such organizations from taxes and oversight as religious freedom. It is not uncommon to find specific exemptions for religious cemeteries within burial law. Counties, cities, and taxing districts operate cemeteries and do so by authority of specific burial laws. Taxing districts become mini-governments unto themselves, including the creation of cemetery districts, district director elections, and taxing authorities. State burial laws will specifically authorize cities and counties to enter into active cemetery ownership and/or management agreements and, in some cases, to collect property taxes within a defined cemetery district. Most modern cemeteries rely on endowment or perpetual care funds to provide for maintenance. Specific burial laws may exist in the various states regulating how such funds will be invested, managed, used, and accounted for. Burial laws have created state agencies for the single purpose of oversight and audit of such funds. Criminal statutes exist for violation of such burial laws.

Protection for cemeteries from local condemnation and right-of-way actions can be found in various state burial laws. Highways, both state and local, can represent a major threat to the continued characteristics of a cemetery. Burial laws in many states make it most difficult to condemn potential burial space or existing burials for public right of way. It is not uncommon to find, when flying over cemeteries, most unusual detours taken by major highway systems to avoid a cemetery. Burial laws have protected the rights of the dead over society's need to travel in a straight line.

Local land-use ordinances and zoning may vary over a hundred-year period of time, yet the cemetery remains untouched because of the protection that burial laws provide. Unlike most all other entities,

cemeteries are free to plan land use within their dedicated acreage. Under many burial laws, the laying out and removal of cemetery roadways are allowed without local approval of such actions. Such freedom varies considerably from state to state. Burial laws may require municipal or county approval in one state while another state specifically exempts cemeteries from any such local controls.

Environmental, Building, and Construction Codes

Environmental issues and burial law have collided in many communities. Wetlands, waterway setbacks, endangered species, and other contemporary environmental issues have greatly challenged the long-standing practice of exemptions enjoyed by cemeteries under state burial laws. Much remains to be resolved in this venue.

Building and construction codes are still another area wherein local ordinances and zoning regulations have authority to reach beyond state burial law. Whether construction is for burial purposes (e.g., mausoleums and columbaria, or funeral home and maintenance shops), public health and safety law, in most cases, trumps state burial law. Burial laws have been used to exempt cemeteries from payment of sales tax and certain fees to local government for mausoleum and columbarium development costs. It is argued that such is for cemetery burial purposes only and thus exempt.

Burial laws in many states allow for cemeteries to write and enforce their own rules and regulations, including speed limits, right of assembly, memorial design and content, hours of operation, and decorations allowed within the cemetery. Some burial laws even allow the "cemetery authority" to have what equates to police authority in and around the cemetery for the purpose of protecting the cemetery and enforcing its rules and regulations.

Cemetery Abandonment Law

The abandonment of cemeteries is addressed in some state burial laws. An abandoned cemetery located at the corner of a large tract of land may be protected should subdivision or land development proposals aim to eliminate the cemetery. Burial law in some states will allow for an extensive court review regarding a court-supervised relocation of a small cemetery should development threaten. Federal bankruptcy courts have had some success in overcoming state burial laws with relationship to liquidating land. Such actions viewed the rights of existing burials as a first position "creditor" when considering distributions of assets to cover relocation costs. Burial laws have been created to declare abandoned cemeteries as historical sites, thus affording legal protection. Burial laws can protect abandoned graves by establishing a "buffer" of 5 or 10 feet around such graves and by declaring these sites as dedicated cemetery lands.

Burial Law on Individual and Family Rights

Burial law in the United States often will address family and personal rights of burial within cemeteries. Considered by many to be a "right of sepulcher," control of burial space is maintained by families under burial laws even during foreclosures and seizure attempts. Burial law may forbid listing of such burial rights as an asset or using the same for collateral in the areas of finance. Graves under many state burial laws are exempt from seizure in legal disputes involving financial awards. Common within burial law, but not common in method and approach, are provisions for descent of title to unoccupied graves. In some burial laws, even title to occupied graves descends to a varying list of heirs.

The right to control a grave's use can be found in some burial laws. When family disputes arise regarding who might be using one or more graves owned by a now-deceased occupant, burial law will come into play. Cemetery rules and regulations may be the "law of last resort" in such disputes. Divorce, remarriage, and blended families present major issues that burial law may remain silent over.

Title conveyance and resale by families are covered under some burial laws. The questions of what title is and what title consists of often are addressed under burial law. Burial laws may address the issue of quit claim and warranty deeds for cemetery graves and/or burial rights. Burial law often refers to the cemetery as being the recording agency in such transfers of ownership rather than agencies of public record, such as the county courthouse. Generally, lot owners do not hold a fee simple interest in the real estate, but have a type of

easement permitting their use of assigned spaces for the interment of human remains, subject to the regulations of the cemetery.

Disinterment and Desecration Regulations

Burial law and/or public health law address disinterment issues within many states. Just who has standing to order a disinterment and who has the right to object? Burial law often will conflict from state to state on such authority. Must all living children of a deceased parent agree to disinter? What if the disinterment request would result in separating the spouse and/or children of the deceased? What if disinterment is requested for cremation purposes? Burial law can be most specific in such cases or simply refer to the cemetery's rules and regulations.

Society seems to hold great disdain for the desecrator of graves. Burial law in some states imposes severe penalties upon the convicted desecrator of graves, even including prison time. State legislatures have acted with record dispatch to plug loopholes found during cases of grave desecration.

Burial Law on Business Operation

Contemporary burial law may address the "business of cemetery." Some states forbid for-profit organizations from operating within a cemetery, whereas other state burial laws may forbid funeral homes from being built upon the cemetery or from being owned by a cemetery business. Burial law has been so detailed as to restrict the sale of certain types of monuments by cemetery businesses and has restricted certain types of ownership of these businesses. Special exemptions from business regulation may be found in burial law, most commonly with businesses operated by religious organizations. Licensing of cemetery businesses can be addressed specifically in some burial law. During the past half-century burial law in some states has addressed, in detail, funding requirements for businesses that sell, in advance of need, cemetery goods and services. Known as preneed trust laws, such laws can be found under identified burial law codes. Records generated by cemeteries regarding burial locations and detail of arrangements made at the time of burial are protected under some burial laws.

Special Jurisdictional Authorities

Burial law may establish special jurisdictional authority to coroners, prosecutors, and special oversight agencies. Coroners are referenced in burial law as having a specific right to operate and control a cemetery. Still other burial laws will authorize a state agency to seize control of a cemetery for the purposes of protecting existing records and business activities.

Burial laws do vary considerably from state to state. Industry groups such as the International Cemetery, Cremation and Funeral Association have produced model legislation for consideration by states seeking such. The evolution of burial law in the United States has been slow, yet burial laws of the 19th century are notably different from those of the 21st century.

Paul Elvig

See also Cemeteries; Cemeteries, Pet; Cemeteries, Unmarked Graves and Potter's Field; Cemeteries, Virtual; Funeral Industry; Funeral Industry, Unethical Practices; Green Burials

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Buried Alive

Burial alive has been used as a form of torture to induce panic and physiological breakdown, and state endorsed and illegal cases have been documented from India, Russia, China, the United States, and Europe. This entry focuses on a much more extraordinary form of live burial: that which occurs as a part of social and cultural practice. Being buried alive is not simply a form of physical disposal; it also serves an important function in facilitating immortality or special deaths. It can be used to immortalize kingship, allowing the surviving family to maintain a special status through kinship bonds with an immortal ancestor. It can also be used to dispose of unwanted children, allowing the parents or relatives to effectively miss the point of death. In cases of sacrifice and regicide, kings, women, and children can transcend death either to avoid repercussions or to achieve immortality. Being buried alive is also feared, and in the 19th century, this fear affected coffin design and the material used to dispose of the dead.

Regicide and Live Burial: The Anthropological Evidence

Among the northern tribes of the Dinka of southern Sudan, there is the memory of regicide. It has been decades or more since a leader has been buried alive; however, when it did take place, it was an important means for the continual legitimization of power by the ruling family. The act of being buried took several days. A large hole was excavated at the highest point within an ancient cattle-campsite. Two wooden platforms were constructed, and for 2 days songs were sung to honor the bulls. Afterwards, and with the family gathered, the bulls were slaughtered, and a bed was made from their hides. While the bed was being constructed, the ritual entered a liminal stage involving feasting and sexual promiscuity. After the bed was completed, war shields were placed on it, the king was interred, and a chamber was constructed within the hole. The chamber was covered with cow dung, but a small hole was left in the surface so the men of the tribe could ask the incumbent for divination until he stopped replying and had finally been taken into the earth. When the chamber collapsed, a shrine was constructed on the site marking the completion of the process of the king passing into the afterlife. This transition was unique to his role as chief, which allowed him not just a special death but to become associated with Dinka ideas of immortality and divinity.

The anthropologists who reported the burial act described in the previous paragraph did not actually witness the act of regicide, and the practice seems to have been outlawed with the advent of British imperial colonization. This has led to controversy surrounding this topic and, as with the study of sacrifice, anthropologists have suggested that the practice of regicidal live burial is symbolic and never actually took place. However, scholars of this topic must be careful not to sanitize alien societies by forcing them to fit with Western attitudes and ideals.

Infanticide, Savage Society, and the 19th-Century Attitude

Before the birth of academic anthropology, colonial administrators and military officers reported on the people in the British Empire. In 1881, the deputy commissioner of Hoshyārpur in the Punjab reported that hundreds of female children were killed annually, buried in a *gharras* or water pots at the end of a ritual designed to bring male children. According to similar sources, if a mother from the Irulas or Nilgiris was driven to hunger, she could bury her child alive in anticipation of its final misery, believing this to be a merciful means of death. Such reports of infanticide were published in London and may have been among the social justifications for colonizing and converting the "savages." It is perhaps notable that many of these cases were never actually witnessed by the colonial officials, generating problems similar to those surrounding cases of regicide. However, that there is a significant favor for male children is witnessed today through the Indian government's need to outlaw ultrasound scans for fears of widespread selective female abortion. It is also worthy of note that in 2007, the Indian media reported the survival of a 2-year-old girl buried alive by her relatives in the Mahbubnagar district. Female infanticide may have been practiced, but probably not on the scale suggested by the colonial officials, who reported whole villages with no female children.

Buried Alive and Human Sacrifice: Archaeological Evidence

Contrary to the view of colonial officials, live burial is a feature of complex societies, and evidence has been found of live burial in some of the earliest city-states. The bodies of slaves, or workers, were left walled up in Egyptian pyramids, buried alive to accompany the dead king into the afterlife. Possibly the most striking case known is from the ancient Mesopotamian city of Ur, located in modern Iraq. Within the cemetery in the middle of this city were the tombs of several members of the royal family identified from the accompanying cylinder seals. The 16 royal tombs consisted of a vault containing the body and treasures; outside of the vault was a ramp providing access to the chamber and a number of antechambers with dozens of retainers buried in full costume and the paraphernalia of their role. There is some debate surrounding how these retainers died, and a small cup found near each skeleton suggests they were poisoned, but these cups may have contained sedatives, drugs, or alcohol. Poison may not have been needed and if a sedative was used, the retainers would have simply died in their sleep, buried alive—such a death could transcend mortality. It is just as likely that these individuals were buried alive within their chambers. This case highlights an interesting problem: It is almost impossible to identify having been buried alive as the cause of death in ancient corpses, and researchers can only speculate how the retainers at Ur actually died.

The most convincing cases come from unique graves. One of these is the burial of a 6th-century Anglo-Saxon woman found within a contemporary cemetery in Sewerby, United Kingdom. In this inhumation, she was found laying face down with arms and legs out and in the appearance of flaying about. At least visually the body of this woman gives the impression of having been buried alive, against her will. A similar case exists from the Iron Age hill fort at Danebury, United Kingdom, where bodies, placed in grain storage pits, seem to have been weighed down by large stones. One of these bodies, like the Sewerby woman, had its arms outstretched and seems to have been buried alive under the stones. These two cases have been interpreted in different ways. The Sewerby woman is regarded as having been murdered, a deviant burial in an otherwise typical cemetery and an indication of some type of special execution, perhaps for witchcraft. In contrast, the Danebury burials have been interpreted as ritual sacrifices linked to a cycle of fertility and rebirth. However, in both of these cases the underlying motivation for the action was not, as it had been in Mesopotamia or among the Dinka, to create an impression of immortality by hiding death. Instead the purpose of live burial has been interpreted as a means to dispel or destroy evil, a bad harvest or hostile magic, or a curse or bad luck.

Fear, Superstition, and Material Culture in the 19th Century

In the cases discussed in this entry, it has been difficult if not impossible to prove that live burial actually took place, and each of these examples are hotly debated. However, the fear of being buried alive does manifest itself within coffin and grave design. In the 19th century this fear was particularly acute, and a large number of safety coffins were designed, particularly during the cholera epidemics. Over 30 different designs were patented in Germany. The first recorded example is that of the Duke Ferdinand of Brunswick's design in 1792; it had a window, a tube for air, and a lock instead of a nailed-down lid. Other designs included ladders, cords, bells, flags, and breathing or feeding tubes. Although there is little evidence to suggest that people actually used these features, glass-paneled coffin lids have been found in England. Two coffins with 6-inch square windows over the head end were discovered from Redearth, a private burial ground in Darwen, Lancashire, United Kingdom. Presumably these widows were too small to allow the incumbent to break the glass and escape, but they were large enough to allow people at the funeral to look into the coffin and determine the condition of the body—live or dead.

The fear of being buried alive was inspired not just by the increased mortality rates of the cholera epidemic but by stories of people who awoke just before burial. Indeed, painters and poets enjoyed the topic, and Edgar Allan Poe wrote *The Premature Burial* in 1844 and returned to the theme repeatedly during his writing career. Such urban legends are still about today, partly inspired by TV culture

and the Internet. As recently as 1995, an Italian manufacturer invented a safety coffin that included an emergency alarm, two-way microphone/speaker, a torch, oxygen tank, and a heartbeat sensor/stimulator. However, as most corpses are drained and embalmed, these seem to be redundant additions to modern coffins.

Torture and Execution

In late medieval France and Germany, women guilty of murder and occasionally those believed to be witches were burned or buried alive. In Germany this burial often involved the inclusion of thorns or being staked to the ground, and it was thought that being buried alive would be much less likely to result in the return of a vengeful revenant than would hanging, which was the usual treatment for men. Indeed, live burial was a punishment in ancient Rome, and vestal virgins transgressing their vow of chastity were reported to have been buried alive. This is a tradition that started before Imperial Rome but survived throughout. Kings instituted the punishment of live burial, but classicists report only a small number of recorded cases occurring when Rome was in political crisis, so these might be better understood as sacrifices. Indeed Pliny the Elder gives accounts of pairs of Gauls and Greeks being buried alive in Rome as human sacrifices at times of great stress.

Conclusion

In summary, live burial can take on an important role in society, but as these examples indicate, this is likely to be specific to certain members of society, such as kings, women, and female children. The act of live burial masks the process of dying and the onset of death. It can be used as a means to transcend death and to create immortal ancestors. A process like this can be important for the surviving family and helps legitimate their roles as an elite regent group. Similarly, ancient society probably practiced live burials, and it is documented in ancient Mesopotamia, ancient Egypt, and Rome. However, anthropological and archaeological debates demonstrate that it is a controversial topic and is unfortunately an area that can be subjected to modern Western sensibilities. Being buried alive has also been feared. In the 19th century, coffin designs were produced that were intended to prevent loved ones from being buried alive, and although these never entered mainstream material culture, glass-fronted coffins have been found in the crypts of the middle classes.

Duncan Sayer

See also Death, Anthropological Perspectives; Immortality; Infanticide; Transcending Death; Witches

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Cancer and Oncology

The American Cancer Society projects that in the United States alone, 1,437,180 people will be diagnosed with cancer and 565,650 will die from the disease in 2008. Accordingly, understanding what cancer is, what factors may contribute to its development, what cancer screenings and treatments are available, and most importantly, how to prevent cancer, are all important topics for consideration.

What Is Cancer?

Cancer is a group of more than 100 different diseases, all characterized by cellular growth and division gone awry. Normally, when the body produces cells, younger cells divide to form the new cells that will replace the old ones as they die off. However, if cells continue to divide, even when new cells are not needed, an extra mass of cells called a tumor can form.

There are two main types of tumors: benign and malignant. Benign tumors are not cancerous and generally do not spread to other body locations. Malignant tumors, on the other hand, are cancerous and may spread from the tumor to other body parts by traveling through the bloodstream or lymphatic system. Cancer that has spread to other body organs is said to have metastasized. Not all forms of cancer develop into malignant tumors, though. Some, like leukemias for example, develop in blood cells.

Malignant tumors and cancers are classified into four major types, the majority of which are carcinomas. Carcinomas are cancers that develop in epithelial cells, which line the surfaces or cover internal organs. Sarcomas develop in bone, cartilage, fat, connective tissue, and muscle; leukemias develop in the blood cells and bone marrow; and lymphomas are cancers that originate in the lymphatic system.

Cancer Incidence and Mortality

Cancer is the second leading cause of death in the United States, accounting for one in four deaths. Among men, the five most commonly diagnosed cancers, excluding skin cancers, are prostate, lung, colon, bladder, and non-Hodgkin's lymphoma. Among women, the five most commonly diagnosed cancers are breast, lung, colorectal, uterine, and non-Hodgkin's lymphoma, in descending order of frequency. The five cancers with the highest mortality rates among men are lung, prostate, colon, pancreatic, and leukemia, respectively. For women, the cancers with the highest mortality rates are lung, breast, colon, pancreatic, and ovarian. Childhood cancers, over half of which are leukemia and brain and nervous system cancers, are the second leading cause of death in children.

Cancer Risk Factors

Over the years, researchers have struggled to answer the question, "What causes cancer?" The two main categories of risk factors that have been

identified are heredity, which is uncontrollable; and environment, or factors that people are exposed to that are often modifiable and controllable. Heredity, or inherited gene mutations, increases one's risk of developing cancer compared to the general population, but it accounts for only about 5% to 10% of cancers. Because environmental risk factors are estimated to account for 75% to 80% of cancer cases and deaths in the United States alone, many studies have focused on identifying risk factors that may increase one's chances of developing cancer.

Tobacco

In 2007, smoking alone was expected to cause 168,000 cancer deaths, and tobacco ranks as the single greatest preventable cause of death in the United States. Smoking and tobacco use increase the risk for at least 15 different types of cancer and are primarily responsible for over 30% of all cancer deaths and roughly 80% to 90% of lung cancer deaths. Additionally, approximately 3,000 nonsmokers die annually from the effects of secondhand smoke.

Obesity

Approximately two thirds of Americans are overweight or obese, and after tobacco, being overweight or obese is the most preventable risk factor for cancer. Unfortunately, the relationship between obesity and cancer is not well known despite the fact that approximately one third of cancer deaths are attributed to poor nutrition, physical inactivity, overweight, and obesity.

Obesity and physical inactivity are associated with colon, liver, pancreatic, esophageal, kidney, gallbladder, endometrial, prostate, and postmenopausal breast cancer. Further, the American Cancer Society reported that being overweight is a risk factor for the development of some lymphomas and leukemias. The risk for developing cancer does not apply simply to those who are clinically obese. One's cancer risk increases steadily as weight increases from normal weight, to overweight, to obese.

Overweight and obesity may to contribute to cancer in several ways. For example, being overweight triggers high estrogen levels, which are associated with both postmenopausal breast and endometrial cancer. High insulin levels, which are affected by obesity, may also play a role in the development of both of those cancers. Gastric reflux, exacerbated by overweight and obesity, is a leading risk factor for the development of esophageal cancer, and colon cancer may, in part, be related to high insulin levels. Finally, obesity can trigger inflammation, which may possibly be associated with several forms of cancer.

Alcohol

Alcohol is an established risk factor for cancer of the mouth, throat, larynx, liver, esophagus, and breast. Although moderate alcohol consumption reduces one's risk for cardiac disease, such is not the case for cancer. In fact, even one alcoholic drink per day can significantly increase breast cancer risk, and colon cancer risk increases with two drinks per day. Mouth, throat, and liver cancer risk increases with over two drinks per day, and the risk is significantly greater among those who both smoke and drink.

Infectious Agents

Infectious agents, including viruses and bacteria, are responsible for 15% of cancers worldwide. The human papillomavirus (HPV) is the primary cause of cervical cancer and is related to some cases of penile and anal cancer; hepatitis B and hepatitis C are major causes of liver cancer. Infection with *Helicobacter pylori*, a bacterium that causes stomach ulcers, increases the risk for stomach cancer and for lymphoma of the stomach lining. Human immunodeficiency virus (HIV) is associated with increased risk for lymphoma and Kaposi's sarcoma, and the Epstein-Barr virus, a common virus that causes mononucleosis, has been linked with Burkitt and immunoblastic lymphomas, as well as nasopharyngeal carcinoma. Human T-cell lymphocytotropic virus is associated with a specific form of T-cell lymphoma.

Environmental Risks

Other known risk factors for cancer include ultraviolet sunlight; cancer-causing chemicals in the workplace; and air, water, and soil pollution, including radon. About 1 in 20 homes has elevated

levels of radon, a naturally occurring radioactive gas, and about 20,000 lung cancer deaths annually are caused by radon exposure in homes.

Another potentially serious risk factor for developing cancer is radiation exposure. Ionizing radiation is invisible, high-frequency radiation that can damage DNA or genes. Everyone is exposed to small doses of ionizing radiation from the earth's atmosphere via cosmic rays, sunlight, soil and rocks in the ground, and other sources, but these levels of radiation only account for a very small percentage of one's total cancer risk. However, some people are exposed to much greater levels of ionizing radiation during certain diagnostic and treatment-oriented medical procedures.

Patients who receive radiation to treat cancer or other conditions may be at increased risk for developing cancer in the future, and X-rays used to diagnose or screen for disease also expose people to ionizing radiation. The dose of radiation from diagnostic and screening procedures is much lower than the dose used to treat a disease, but some diagnostic procedures pose greater risks than others. For example, the radiation dose of a chest X-ray exposes a person to the equivalent effective dose of 2.4 days of naturally occurring background radiation. A computerized axial tomographic (CAT or CT) scan of the abdomen exposes one to the amount of radiation equivalent to 500 chest X-rays and 3.3 years of naturally occurring background radiation. A cardiac CT scan for a woman produces the radiation equivalent of 1,070 chest X-rays and 7.1 years of natural background radiation.

Oncology

Oncology is the branch of medicine that concentrates on the prevention, development, diagnosis, and treatment of cancer; doctors who treat cancer are called oncologists. Medical oncologists treat cancer with chemotherapy; surgical oncologists biopsy, stage, and perform surgery to remove cancerous tumors; and radiation oncologists use radiotherapy, or therapeutic radiation, to treat cancer or to shrink tumors to reduce pain and suffering of patients. Oncologists often first become involved with patient care at the time of cancer diagnosis.

Diagnosis

Correct diagnosis is critical to determining the most effective therapeutic options and patient prognosis. Cancers are diagnosed at different stages of development and these stages are based on the size and location of the tumor or cancer, and whether or not the cancer has spread. One of the two most common methods of staging cancer is the TNM system. "T" relates to the extent of the primary tumor, "N" to regional lymph node involvement, and "M" to distant metastases. Those three factors determine whether the cancer will be diagnosed as Stage I, II, III, or IV. Generally, Stage I cancers are localized and often curable, whereas Stage IV cancers have spread or metastasized to distant locations throughout the body. The prognosis for Stage IV cancers is generally poor.

Treatment

Most cancers can be treated and some can even be cured. The specific treatment protocol utilized will depend on the cancer type and stage, as well as the general condition of the patient and his or her ability to withstand treatment.

Surgery

Surgery is often the first line of defense in cancer treatment and sometimes can successfully remove the entire tumor, particularly in the early stages of disease. Sometimes tumors cannot be completely removed because they are embedded in or attached to an organ, and removal would endanger the patient's life. In that case, surgery may be used to debulk, or remove some of the tumor mass to improve one's quality or length of life. New surgical techniques such as cryosurgery, which freezes tumor cells, and radio frequency ablation, which heats tumor cells and requires only small incisions to insert surgical instruments, result in easier recovery and fewer complications.

Chemotherapy

Chemotherapy is the use of medication to destroy cancer cells and/or shrink tumors. Chemotherapy is used when cancer is located in an area that makes surgery impossible or too risky or when the cancer is not a solid tumor that can be surgically removed,

as in leukemias. Chemotherapy may also be used when surgery has been unable to fully remove all tumor cells or when cancer has metastasized to distant body regions. Finally, chemotherapy may be utilized when surgery appears to have removed all observable cancer, but there is a risk of cell migration; in this case, chemotherapy is used as adjuvant therapy. Chemotherapy is often less noxious than it used to be as a result of drugs that better manage the negative side effects, such as nausea and low white blood cell counts that can cause life-threatening infections and other problems.

Radiation Therapy

Radiation therapy uses high-dosage radiation from X-rays, gamma rays, and other sources of radiation to either destroy cancer cells or shrink tumors. Radiation is often administered by machines that emit external-beam radiation. However, radiation can also be given internally, either by inserting a radioactive source into the body near tumors or cancer cells or by infusing radioactive substances into the body via the bloodstream to target cancerous tissues in the body.

Hospice and Palliative Care

When it becomes clear that treatments are ineffective at slowing the progression of cancer and it has become terminal, treatment may include hospice and palliative care. Hospice care is a multidisciplinary, holistic approach to patient care, usually home-based in the United States, and is provided for persons suffering from terminal illnesses, including incurable cancers. Hospice patients receive palliative care, which is aimed at managing symptoms and providing comfort but not curing one's cancer.

The field of oncology continues to develop more advanced cancer treatments through the process of testing new surgical, chemotherapy, and radiation treatments in clinical trials. A clinical trial is one of the final stages of an extensive research process that tests new treatments that have shown success in laboratory tests. Several promising cancer treatments that are currently being tested in clinical trials, or have recently been approved, include cancer vaccines to treat cancer, gene therapy that tailors treatment to a specific tumor's genes, and targeted therapies that kill cancer cells while preserving healthy cells. The development of these and other cutting-edge cancer treatments is promising, but regardless of how successful cancer treatments become in the future, it is always preferable to prevent the development of cancer in the first place.

Cancer Prevention and Screening

Cancer Prevention

The risk of developing cancer can be significantly reduced by making moderate lifestyle changes. The American Cancer Society as well as the panel that published the 2007 report *Food, Nutrition, Physical Activity, and the Prevention of Cancer: A Global Perspective* have established guidelines on nutrition, physical activity, and other preventive measures. Diet and physical activity guidelines include maintaining a healthy, lean weight; adopting a physically active lifestyle with a minimum of 30 minutes of daily exercise and limited sedentary habits; consuming a plant-based diet, low in red and processed meats, salt, calorie-dense foods, and sugary drinks; and limiting alcohol consumption to one drink per day for women and two per day for men. Vitamins and supplements are not generally recommended for cancer prevention.

Additional recommendations include protecting oneself from excessive sunlight, especially during peak radiation hours; as well as avoiding tanning beds for the prevention of skin cancer. Immunizations for hepatitis B and HPV are recommended, as is avoiding risky sexual behaviors that can contribute to HPV, HIV, and hepatitis B and C, all diseases associated with the development of cancer. Finally, the American Cancer Society recommends regular screening and self-examinations for certain types of cancer.

Screening and Early Detection

People who are diagnosed with cancer at a late stage are at significantly greater risk of dying from their cancer, but recommended screening tests can improve survival by detecting cancer at an early stage when treatment is more effective. Screening may even prevent the development of

some cancers by finding and removing premalignant abnormalities, as in the case of some skin and colon cancers.

Both the American Cancer Society and the Centers for Disease Control and Prevention have presented nationwide objectives and initiatives for early detection of some cancers. Mouth and skin cancers can be identified at early stages by dental and medical examination, respectively, and early detection screening measures such as mammography, colorectal screening, and pap tests have been found to reduce mortality from breast, colon, rectum, and cervical cancers. In many cases, colorectal cancer can actually be prevented because most colorectal cancers develop from precancerous polyps, which can be removed during a colonoscopy screening procedure. It is estimated that half of all deaths from colorectal cancer could be prevented by colorectal screening, yet only two in five Americans over the age of 50 have had colorectal screening.

Although many believe the prostate-specific antigen test and digital rectal exam screening measures have contributed to declining prostate cancer deaths, currently, the American Cancer Society and the Centers for Disease Control and Prevention have not set any formal guidelines for prostate cancer screening. Both groups report that there is currently insufficient evidence to make specific recommendations either for or against prostate cancer screening.

In addition to screening, people should be alert for changes in their body that may indicate cancer. Cancer may cause a wide variety of symptoms, such as unexplained lumps in the body; changes in warts or moles; sores that do not heal; nagging coughs or hoarseness; changes in bowel or bladder habits; unusual vaginal, urinary, or rectal bleeding or discharge; indigestion or difficulty swallowing; unexplained changes in weight; overwhelming fatigue; unexplained anemia; night sweats; and enlarged lymph nodes. This list is fairly extensive and the symptoms often not caused by cancer, but if these or other physical changes persist, medical consultation is recommended. Additionally, because some cancers have no obvious symptoms, routine physical exams are recommended by some authorities.

Controlling risk factors to help prevent the development of cancer can possibly reduce the number of newly diagnosed cancer cases by at least half. And when prevention is not successful, oncology's continued development of new and improved therapies can also contribute to decreased mortality, increased quality of life, or both, for those diagnosed with cancer.

Brenda Moretta Guerrero

See also Acute and Chronic Diseases; Palliative Care; Terminal Care; Terminal Illness and Imminent Death

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Cannibalism

Cannibalism, also called anthropophagy, is the human act of eating parts of the human body, including, but not limited to, flesh, muscles, and blood. The origins of the word are a result of a conversational misunderstanding between Christopher Columbus and a guide referring to a group of barbaric people in the West Indies who ate human flesh. While the natives referred to them as Caribs, Columbus called them Canibales by mistake. This idea of savage cannibalism became more popular with the voyages of Captain James Cook in the Pacific Ocean and his ship's many dialogues and encounters with the Māoris, Polynesians, and Tahitians. Reports of cannibalism exist throughout the world, with the first records dating back 500,000 years. These reports have usually focused on groups of people whom the people of the Western world have considered to be barbarians, savages, or others.

Falsified literary reports issued by various governments to spread the rumor of cannibalism in countries such as Russia, Poland, and Ireland in times of crises and war as a means of propaganda have been documented. This is not to say, however, that cannibalism is a complete falsification. Social scientists view societies that practice cannibalism and incidents involving cannibalism in one of three separate ways: psychogenic cannibalism, a means of satisfying mythic and overarching psychosexual fantasies and desires; utilitarian/adaptive cannibalism, an adaptation of hunger or other material deficiency; or hypothetico-deductive cannibalism, part of the overall universal order and a normative function in society.

Within these analytical frameworks of understanding cannibalism, there are also five different categories for various acts of cannibalism. Exocannibalism is the cannibalism of war and the eating of the "other" who is not a member of one's tribe, whereas endocannibalism is the cannibalism of those who are either in, or related to, one's tribe. Survival or emergency cannibalism is the consumption of a human for purposes of nourishment and protein deficiency, and chaotic cannibalism is associated with a power or force that is believed must be eaten to be destroyed. The last type, lunatic-fringe cannibalism, is often dramatically reported; its most important benefit is the reinforcement of the stereotype of cannibalism.

The cannibal ritual of the literal eating of the flesh and blood of a fellow human has been hard to definitely establish because the majority of early accounts with supposed cannibals were based off an ethnocentric colonial point of view. The sparsely populated country of Papua New Guinea has long been spoken of as having an interior populated by cannibals. Tribal groups such as the Fore, the Huli, the Kutubu, the Strickland-Bosavi, the Duna, and the Mianman have allegedly practiced cannibalism. However, the sources for these acts of cannibalism tend to be unreliable as they usually arise as one tribe's commentary on their neighboring, and often enemy, tribe.

There are, however, two strands of evidence that legitimatize cannibalism more so than unreliable neighboring accounts. The outbreak of Kuru, which is a disease of the nervous system studied by Nobel Prize recipient Daniel Gajdusek in the Fore people, tied the degeneration of the cells of the brain to being passed from person to person by cannibalism. Another source that accounts for an accurate depiction of cannibalism is a detailed description of the Miamman raid on the Owininga people of Papua New Guinea, where cases of cannibalism occurred. The police account of the report, which was backed up by witnesses and defendants, cited that the bodies of the victims were cut up and later eaten with a side of taro.

Cannibalism also exists in cultures in the form of mythology. In European and American cultures, creatures such as werewolves, witches, and vampires often consumed human flesh or blood for power and various nefarious purposes. In the Bimin-Kuskusmin culture of Papua New Guinea, there are many tales of witches, sorcerers, and female tricksters (known as *kamdaak waneng*), all whom eat various parts of humans in order to gain power.

Groups of people who have been accused of practicing cannibalism have a number of similar traits. First, they come from societies that are politically homogeneous, and where the local government is the supreme form of power. Second, these people associate themselves with societies that have a history and culture of maternal dependency, a subdued taboo against sexual intercourse, and suppressed male aggression against both males and females. Finally, they come from societies

where there is a significant level of food stress, especially when it includes protein. It is important to note that just because one of these groups possesses these characteristics, does not mean that they will engage in cannibalism (there is no documented link between hunger and desire to resort to cannibalistic practices, for instance).

Emergency cannibalism is highlighted in depth in this entry, as it is the most prevalent type in both historical and contemporary literature, and it continues to be the main form of cannibalism reported in the industrial Western world. Because acts of emergency cannibalism often occur in sparsely populated places, and the practices often belong to a dying, war-like group who is more intent on survival than cultural preservation, there is very little evidence of specific tribes actually practicing this type of cannibalism.

Societies or time periods during which such emergency cannibalism is thought to have existed include the Anasazi Indians of Chaco Canyon in the American Southwest; in Ireland during the Irish potato famine; in China during the Three Kingdom period, the Tang period, and the Han period; during the siege of Leningrad in the early 1940s; and in the Jewish ghettos during World War II. These reports are based on personal accounts and archaeological findings.

There are a number of more prominent incidents in the past 2 centuries that indicate the existence of emergency cannibalism. The first is the infamous case of the Donner Party. In 1846, the Donner Party, organized by George Donner, set off across the Rocky Mountains toward the Sacramento Valley. After disregarding the advice of the group's guide, they were trapped in a series of snowstorms for well over a month. After all the food, including their oxen, horses, and dogs, was diminished, the group contemplated eating the members of their party who had already died. After 5 days of hesitation, they began eating the remains of Patrick Dolan. At the end of their ordeal, approximately 45 people survived, many of whom resorted to emergency cannibalism.

Another well-documented example of emergency cannibalism occurred when an F-227 airplane crashed in the Andes Mountains of Argentina in 1972, carrying members of the Uruguayan rugby team called "The Old Christians." In brief, after using up all of their rations after the crash, the survivors began to consume the bodies of those who had already died; they ate everything from their buttocks, to their hands, to their brains. Just like the Donner Party, there was fear of the social taboo of cannibalism and especially the commentary that their devout Catholic upbringings had for respect of the body. In the end, all of the survivors eventually resorted to cannibalism. After a more than 2-month ordeal, the remaining 16 survivors were rescued and quickly became national heroes. As the Roman Catholic Church justified it, if they had refused to eat the bodies, they then would have been committing suicide, which is a greater offense than cannibalism.

One of the most recent reports of cannibalism occurred on a Vietnamese refugee boat in 1988. After leaving the port of Truc Dang, the motor on the ship faltered and the junk became stranded, as it did not have a sail or a replaceable motor. After running out of food and being ignored by both Japanese and American vessels, Phung Quang Minh, the self-appointed captain of the ship, suggested that the group begin using the bodies of the dead for the living. Unlike becoming the heroes of the Donner Party or Uruguayan air flight 571, Phung and nine others were incarcerated after the junk arrived on the island of Luzon in the Philippines; about half of the original crew survived.

Although still uncommon, contemporary events of cannibalism are found in popular culture, emphasizing the modern world's portrayal of cannibalism as a social taboo and an act of "the other" and "the savage." A contemporary story of cannibalism involves Armin Miewes, who posted an advertisement for a person who was willing to be eaten; Bernd-Jürgen Brandes answered the article and was later killed and eaten. Miewes, who stored parts of Brandes's body for over 6 months, was placed on trial and was later convicted.

Another modern cannibalistic event occurred when Chilean shock artist Marco Evaristti fed dinner guests meatballs that were made out of his own body fat removed by liposuction. Although deemed cannibalistic by the public, the police and government took no action. Other examples are presented in movies such as Fruit Chan's *Dumplings,* Bartel's *Eating Raoul,* and Demme's *The Silence of the Lambs*.

Andrea Malkin Brenner

See also Body Disposition; Christian Beliefs and Traditions; Death, Anthropological Perspectives; Legalities of Death; Popular Culture and Images of Death

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Capital Punishment

Since at least the beginning of written history societies have put people to death, both as a redress to social harms and as a means to control deviant and criminal behaviors. Widespread opposition to capital punishment, however, is a more recent phenomenon, first emerging during the European Enlightenment, as new political philosophies began to take root in the body politic and changing social attitudes toward death and dying emerged. This entry explores the general shift in the cultural orientation toward capital punishment in Europe and the United States, recent changes in its use globally, and contemporary issues regarding the death penalty in the United States.

Capital Punishment in Western Europe and the United States

In 1764, the Italian criminologist Cesare Beccaria voiced the first widely read opposition in Europe to capital punishment. His arguments against capital punishment were part of a shift toward emphasizing individual rights within emerging political and social philosophies. Such philosophies were related, at least in part, to the emergence of new views of life and death in the late 17th and 18th centuries, views increasingly informed by rationalism and science and decreasingly by religion and the traditions of the *ancien régime* that had dominated much of European society and culture for hundreds of years.

Attitudes toward death had been slowly changing since the end of the Middle Ages, including attitudes toward capital punishment. For centuries prior, social life had been governed by rigid forms of tradition, and death was itself common and communal. People died often and early, and the movement from life to death was still a public event and still governed by an adherence to ritual and an assumption of communal salvation. In the case of capital punishment, prior to the Enlightenment, there was little opposition to the idea that some people deserved to be put to death. Executions were generally grisly, public affairs, often accompanied by torture and prolonged suffering, designed to deter other would-be offenders. Bodies of the condemned were frequently left to rot, burned, or scattered; denying one a proper Christian burial ensured damnation in the next world as well.

By the 12th century, images of individual judgment began to replace those of communal salvation. Where this represented a shift in emphasis toward what the French social historian Philippe Ariès called "one's own death," rituals of condemnation and execution nevertheless changed little throughout the Middle Ages, except in one important sense: where capital punishment was increasingly viewed as a means of suffering by which one could repent and be saved. This is evident, for example, in the well-known *Malleus maleficarum* (Hammer Against Witches), written in 1486, which detailed numerous ways in which those accused and found guilty of witchcraft were able to save themselves through confession, repentance, and punishment. In practice, however, tens or even

hundreds of thousands were put to death throughout the late Middle Ages, the Renaissance, and the Reformation, and aside from crimes of heresy or witchcraft, people were put to death for political crimes, crimes against the king, and common crimes. Some parts of Renaissance Europe (e.g., Venice) restricted the use of capital punishment, and thinkers such as Thomas Moore and Erasmus debated its merits, but by and large there was little opposition to, and many opportunities that favored, its use, including wars between states, various inquisitions, the Reformation and Counter-Reformation, and peasant revolts.

While Beccaria is credited with publishing, in 1764, the first widely read opposition to the use of capital punishment, by this time its use was already declining throughout much of Europe. This decline coincides with changing views of death itself in Western Europe that were a result of both social and scientific changes. The emerging bourgeoisie were living longer lives due to advancements in medicine and hygiene. Religious views of death as a transition to the afterlife were being replaced by biological definitions of death as the cessation of organic function, as well as secular doubts regarding the existence of any afterlife at all. New political philosophies argued in favor of an inherent right to life as central to the concept of the social contract.

Taken together, these social, scientific, and political changes undergirded Beccaria's opposition to capital punishment, which he published as part of his 1764 treatise *On Crimes and Punishments*. In this work, Beccaria put forth what is referred to today as the "classical" approach to crime control—an approach that is rooted in a utilitarian view of punishment as a means by which to promulgate adherence to the law and deterrence from criminal activities. In the case of capital punishment, Beccaria drew heavily from the work of John Locke and other political thinkers of the time by arguing that life itself was a right that could not be justly deprived by the state. Beccaria further argued that capital punishment was not only unjust but also ineffective; he proffered that prolonged depravation of liberty, and not death, was more effective in deterring people from criminal acts.

Beccaria's work reflects the beginning of the shift in early modern Europe away from the spectacle of public torture and humiliation as a means of social control. This era witnessed the beginning of the use of prisons in western Europe and the northern United States as a means of "correcting" socially deviant and criminal behaviors. Many forms of public punishment were replaced with the "private" depravation of liberty behind the walls of the penitentiary. Yet public executions remained common in Europe and the United States up through most of the 19th and even the early 20th century. What changed during this time with regard to the use of capital punishment was not its public display, but rather the emergence of the idea of "merciful" or even "humane" death. The French use of the guillotine was seen as a progressive step away from the barbaric practices of execution used in the ancien régime, as was the early use of the electric chair in the United States, which was thought to be a humane alternative to hanging or the firing squad.

By the first decades of the 20th century, death itself was becoming increasingly masked behind the closed doors of the hospital and dressed up in the parlors of the mortician. Within a span of only 50 years or so in the United States, a shift occurred in that a majority who had once died at home now died in institutions; similar shifts occurred throughout western European countries. Sociologists and social historians call this the emergence of "hidden" or "invisible" death, and in the case of capital punishment, executions soon followed suit. Public executions were ceased in Britain in 1868, in the United States in 1936, and in France in 1939.

Executions did not become private affairs due to lack of public interest, however; the last execution in the United States drew a crowd of 20,000 and the last beheading in France was a similar public spectacle. Rather, in western Europe and the United States, capital punishment became increasingly hidden from public view in large part *because* of the controversy and spectacle surrounding public executions. The last execution in France was, by many accounts, a drunken and jeering affair, and the last execution in the United States—of Rainey Bethea in 1936—received substantial negative press coverage. By the mid-20th century, executions in western Europe and the United States were conducted under the auspices of technicians and administrators, and the rancorous crowds that accompanied the last public executions in France and the United States were replaced by executions conducted behind closed doors.

Today, executions are almost nonexistent in Europe and are carried out only in front of victims, family members, and prison staff in the United States. Cultural controversy and fascinations surrounding capital punishment remain, however, and while the public spectacle of the gallows or guillotine have all but disappeared, the popularity of executions on the Internet and on video suggests that attempts to politically and culturally repress the spectacle of executions have not necessarily curbed public interest. Geoffrey Gorer argued in 1955 that death itself had become pornographic in the 20th century, in a manner not dissimilar from that of sex itself under the Victorians a century prior, and the rapid growth of multimedia depictions of executions suggests that a new type of "virtual gallows" has emerged, perhaps no less popular than those a century ago.

Global Patterns in Capital Punishment

Within the 20th century, capital punishment became an increasingly controversial practice not only in terms of its instrumental value as a mechanism of social control, but also as a representation of culture itself. In the past 30 years, all Western industrialized nations, with the exception of the United States, ceased the use of capital punishment. Some European and South American states had in fact ended capital punishment much earlier, and it is often overlooked that states such as Venezuela (in 1863) and Uruguay (in 1907) were among the first to abolish its use. Today the majority of South and Central American states have discontinued its use, although a majority of Caribbean states still retain capital punishment.

Western Europe represents the most regionally concentrated shift away from the use of capital punishment in the 20th and early 21st centuries, but this shift has been occurring globally as well. Following the breakup of the U.S.S.R., a majority of eastern European states discontinued its use, Belarus excepted. Russia and Latvia still allow its use for a small number of crimes, but within the past decade there has been only one known execution in Russia. The democratization of Central and South American states, following years of repressive governments, has likewise seen a decrease in the use of capital punishment.

Globally, as late as 1965, only 12 countries had banned capital punishment, and another 12 had informally discontinued its use. By 2008, about 90 countries had abolished capital punishment and another 30 had not executed anyone for at least a decade. The effect is that the majority of the world's executions are increasingly concentrated in a smaller number of states. According to Amnesty International, 90% of all known executions in 2006 were carried out by six nations: China, Iran, Pakistan, Iraq, Sudan, and the United States.

This small distribution represents the widespread use of capital punishment in both Islamic as well as in authoritarian states. Within Islamic states, only Turkey, Turkmenistan, and Azerbaijan do not use the death penalty. While religion may play a part in the use of capital punishment, the strongest predictor of the use of the death penalty is authoritarian and/or repressive governments. This includes Islamic states such as Iran, Iraq, and Saudi Arabia; communist states such as China, Vietnam, North Korea, Cuba, and Laos; and other despotic or authoritarian governments such as Burma, Zimbabwe, Belarus, and Singapore. Of these states, China by far executes the most people—approximately 1,000 people in 2006—although official figures from China are much lower than most other scholarly estimates.

Capital Punishment in the Contemporary United States

The debate surrounding capital punishment within the United States includes questions regarding the efficacy in deterring or reducing serious violent crime; racial and social class biases present in the use of capital punishment; the potential execution of wrongly convicted persons; the political, social, and ethical desirability of using capital punishment; and the financial costs of capital cases.

Those who support capital punishment tend to believe it reduces or prevents violent crime. Such a position falls within the purview of capital punishment *as* social control, where its primary function is considered one of crime deterrence and prevention. Research is divided on this question. Several studies have found positive correlations between its use and decreasing or potentially prevented homicides, whereas other studies have found no

correlation, or even negative correlations. To date, there is no scholarly consensus on the relationship between capital punishment and deterrence or prevention of homicide specifically or violent crime in general.

Since 1980, however, public support for capital punishment has increasingly taken the form of retribution, not deterrence. Public opinion polls suggest that retribution has become a more popular reason than deterrence for support of the death penalty, reflecting public support for capital punishment *as* social equity. Stated otherwise, more people today believe that capital punishment is justified, even when they do not necessarily believe it functions to deter crime. This change corresponds more generally as well to a rise of overall public support of capital punishment, which was below 50% in the 1960s and rose to a high of around 75% in the 1980s. As of 2007, 62% of Americans were supportive of capital punishment, although this support varies demographically—men more than women, whites more than blacks, Republicans more than Democrats, the middle class more than the poor, and suburbanites more than urbanites or rural populations.

Public opinion polls do not explain, however, why the United States remains the only Western industrialized nation to retain capital punishment. Recent literature on the question offers several competing, and in some case overlapping, explanations. These theories include several recent works that situate American exceptionalism in longer histories of explicit forms of social control and oppression such as slavery, racism, and class conflict; in the tradition of "vigilante values" that first emerged in southern states in the form of lynching and is still present today, where since 1976 about 80% of all executions have taken place in southern states; and in the diverging paths between the United States and countries such as Germany and France during the 18th century, when the latter extended high-status punishments to larger segments of the population, and the former increasingly adopted punitive low-status punishments.

Other scholars have argued, however, that the roots of American exceptionalism are more recent. These arguments have centered on late 20th-century changes in American culture, including the rise in violent crime rates in the late 1980s and early 1990s, growing public fear of crime, the growth of the prison industrial complex and corresponding increases in punitive sentences, changes in media coverage related to violent crime, and the political success of conservative and evangelical movements since 1980. These scholars also point to research that suggests that the use of the death penalty since 1976 is more frequent in minority and poor populations, particularly in African American populations, which are overrepresented both in terms of their overall population in the United States, as well as in terms of capital offenses that have resulted in a sentence of death.

Regardless of the roots of this exceptionalism, it appears unlikely that the legality of capital punishment in the United States will change anytime soon. In 2008, the Supreme Court upheld the use of lethal injection in *Baze v. Rees,* signifying its reluctance to stray far from its 1976 decision in *Gregg v. Georgia,* which reinstated the constitutionality of capital punishment. Four years prior, the Court had overturned capital punishment in *Furman v. Georgia* on Eighth and Fourteenth Amendment grounds, finding that its use was "arbitrary and capricious." Since its reinstatement, however, the Court has heard cases regarding only specific applications of capital punishment, including notably *Roper v. Simmons* (2005), which overturned the practice of executing those who had committed crimes as minors; *Atkins v. Virginia* (2002), in which the Court overturned the use of capital punishment for mentally retarded offenders; and *McCleskey v. Kemp* (1987), in which the Court upheld the execution of McCleskey, who had appealed his conviction by presenting statistical evidence asserting that the use of capital punishment in Georgia was racially biased.

William R. Wood

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Cardiovascular Disease

The abnormal conditions that affect the heart and blood vessels (arteries and veins) are considered under the umbrella of cardiovascular disease (CVD). The major types of CVD include coronary (or ischemic) heart disease, acute myocardial infarction (heart attack), cerebrovascular disease (stroke), arrhythmias, valvular heart disease, hypertension (high blood pressure), and congestive heart failure. Heart attack and stroke are responsible for most CVD deaths. According to the Centers for Disease Control and Prevention (CDC), CVD has been the leading cause of death in the United States for more than a century (except during the 1918 flu pandemic) and claims more American lives than does cancer each year. Although the death rate in the 21st century (2003) as compared to the mid-20th century (1950) has declined, CVD is still the cause of 37% of all deaths in the United States. Current statistics can be obtained from the American Heart Association.

Cardiovascular disease is also the leading cause of death in many developing and underdeveloped countries. It was responsible for 16.7 million (29.2%) of total global deaths in 2003. In industrialized countries, incident of CVD rises with age, whereas in the developing and underdeveloped countries, the trend is opposite: In those countries, more people of a younger age experience CVD. According to the CDC, the decline in CVD death rates in the United States is mainly due to improved medical care and changes in lifestyle. The average age of having a first heart attack is 65.8 for men and 70.4 for women.

Common Types of CVD

Atherosclerosis (a buildup of plaque inside the artery wall) is the primary malefactor in most of the CVDs. Atherosclerosis in the coronary arteries causes the most common type of CVD, coronary artery disease. The plaque buildup reduces blood flow in the arteries resulting in ischemia (oxygen deprivation to the heart muscle). This causes coronary heart disease leading to chest pain (angina) or a heart attack (myocardial infarction). Coronary bypass surgery is a common treatment for blocked arteries. A blood vessel is taken from a leg or the chest and grafted onto the blocked artery to bypass the blockage. Another procedure to improve blood circulation in the heart is angioplasty. This involves cardiac catheterization and flattening atherosclerotic deposits or inserting a stent to open a blocked artery. Two newer techniques are laser angioplasty and atherectomy. These are often followed by a stent procedure.

The second most common type of CVD is stroke resulting from atherosclerosis and arteriosclerosis (loss of elasticity of the arteries or hardening of the arteries), which affect the arteries that deliver blood to the brain. An artery rupture or blockage of the blood supply to the brain or to part of the brain may result in oxygen deprivation. Due to lack of oxygen, nerve cells die within minutes, affecting the part of body they control. Four types of stroke are cerebral thrombosis and cerebral embolism, caused by clots or plaque blockage of an artery, and cerebral and subarachnoid hemorrhages, caused by ruptured blood vessels. A transient ischemic attack (TIA) is a "warning stroke" or "mini-stroke" that produces milder and short-lived stroke-like symptoms. About 15% of all strokes are preceded by a TIA and 25% of these patients die within a year after a TIA.

Assessment and Symptoms

Blood pressure is the most common and easiest way to assess the status of a person's cardiovascular system. A systolic blood pressure between 120 and 139 mm Hg or a diastolic pressure between 80 and 89 mm Hg is considered "prehypertension," while blood pressure reading of 140 over 90 or higher is considered hypertension. This may occur without symptoms, which is why high blood pressure is called a silent killer. Another commonly used method is electrocardiogram, which measures the heart's electrical activity during rest or exercise. Imaging techniques used to diagnose heart disease include magnetic resonance angiography (also called cardiac magnetic resonance imaging), cardiac catheterization, and angiography. Angiography requires inserting a catheter into the blood vessel and injecting a dye into the heart, which helps reveal the condition of the coronary arteries with X-rays. This technique requires hospitalization.

More men than women have heart attacks; however, heart disease is the leading cause of deaths for American women. Women tend to have less-typical symptoms than men, for example, classic chest discomfort. Their symptoms are more subtle, such as weakness, unusual fatigue, cold sweats, dizziness, and anxiety. Many begin experiencing symptoms long before heart attack (some for a month) actually strikes. Other symptoms that may be experienced by both sexes are shortness of breath, pain in chest/shoulder/jaw/elbow, sweating, and indigestion that is not relieved by antacids.

After patients have been diagnosed with CVD, they are usually advised to change their lifestyle so that they can avoid further complications. These changes include dietary changes, exercise, weight reduction, smoking cessation, and stress management. However, when a person is having a heart attack, emergency care is needed. Risk of death can be reduced by half if one gets medical treatment within the first hour of an attack. Heart attack survivors undergo cardiac rehabilitation after they stabilize. Cardiac rehabilitation is designed to help patients improve their cardiovascular fitness and quality of life. However, only 15% to 35% of patients comply with such programs.

Risk Factors

The precursor of heart disease, atherosclerosis begins early in life, taking many years to develop depending on a person's risk factors. The risk factors for CVD are classified nonmodifiable, modifiable, and contributing factors. A longitudinal study, the Framingham Heart Study, and the 1964 report of the Surgeon General identified many risk factors. The Framingham Heart Study began in 1948 and is now following the third generations of Framingham residents. Although risk factors indicate conditions that are related to CVD and not the causation, risk reduction measures should be undertaken early in life in order to prevent CVD in middle age.

Nonmodifiable risk factors are uncontrollable genetic or physical conditions that cannot be changed through modification of lifestyle. They include gender, advancing age, family history of CVD, and race. Although men have a higher rate of CVD than women, it is also the number one health problem for women in industrialized countries. Before age 60, rate of heart disease is significantly higher in men than women; however, after menopause, the risk for women approaches that of men. Also, their outcomes are significantly less favorable than for men. Advancing age is also a major risk factor for CVD. For every 10-year increase in age, the risk of dying of CVD doubles for both sexes; four out of five people who die of heart attacks are over 65.

Family history is another uncontrollable risk factor. Having one first-degree relative with heart attack doubles the risk, and the risk triples with two or more first-degree relatives with heart attack. Furthermore, the risk is stronger when heart attacks in these relatives occur before the age of 55. Moreover, research into the genetic or racial influence on cardiovascular diseases clearly demonstrates that race is highly associated with socioeconomic, cultural, behavioral, and medical conditions, any of which could explain the differences in the incidence of cardiac arrest and associated deaths. Compared to European Americans, heart disease risks are higher among minority people, including African Americans, Mexican Americans, American Indian or Alaska Native people, and more recently, Native Americans. African Americans have nearly a twofold risk for

CVD compared to European Americans, partly due to higher rates of obesity, diabetes, and hypertension. A recent longitudinal study, the Jackson Heart Study is an effort to help the African Americans reduce the risk factors associated with CDV.

Hypertension, hypercholesterolemia, smoking, obesity, diabetes mellitus, and sedentary lifestyle are modifiable risk factors. Hypertension is the most common disease in industrialized nations that leads to increased risk of stroke, heart attack, heart failure, and kidney failure. Regardless of age or gender, hypertension is the best predictor of CVD. Hypercholesterolemia is another modifiable but serious risk factor for CVD. Cholesterol circulates in the blood in several different forms of lipoprotein; high-density lipoprotein (HDL) is protective and low-density lipoprotein (LDL) is damaging. Total cholesterol equals HDL + LDL + 20% of triglycerides.

Smoking and diet are the two most modifiable factors that relate to CVD. Smoking accounts for about 35% of the heart disease around the world. Compared to nonsmokers, smokers are more than twice as likely to develop heart disease and have a stroke. Diets high in saturated fat are a strong risk factor for CVD, whereas diets high in fruits and vegetables protect against CVD. Consumption of fish, antioxidants, lycopene, selenium, and riboflavin are found to be protective against CVD. Excessive alcohol drinking, sedentary lifestyle, and obesity are also modifiable risk factors for CVD. People who have diabetes are more likely to die of heart disease than those whose sugar metabolism is normal, because high glucose levels are damaging to arteries. Currently attention is being paid to a prediabetic condition of being insulin resistant. It is a silent condition that increases the chances of developing diabetes and heart disease. The 1995 Bogalusa Heart Study was the first study to show insulin resistance beginning in childhood to be a significant predictor of CVD. Insulin resistance is a risk factor for developing CVD over time even when the children are not obese. All modifiable risks can be controlled with lifestyle changes and should be considered early on during one's childhood.

Social, psychological, and environmental factors contribute to CVD as well. Low educational and income levels are both positively related to heart disease. Social support and marriage are also important factors, because spouses or friends help patients by encouraging them to seek medical attention, follow the medical advice, and make healthy changes. Being single and having little social support increases the risk of CVD. Those with previous heart attack who lack social support tend to have greater risk for a second heart attack. Although marriage decreases the risk for CVD, it is the quality of the relationship that has a positive effect on one's health. Stress, anxiety, depression, and cynical hostility/anger are positively related to the development and progression of CVD. However, because these variables are related to each other, it is difficult to assess the effect of each variable. Other contributing factors are sleep deprivation, exposure to high levels of environmental noise and pollution, and periodontal disease.

Prevention

The best way to prevent CVD is to control modifiable risk factors and be aware of nonmodifiable risk factors. Most interventions to prevent heart disease focus on reducing hypertension, lowering serum cholesterol and glucose levels, and making healthy lifestyle changes that include smoking cessation, regular exercise, weight management, good nutrition, and stress management. Psychological programs such as anger management, relaxation techniques, and meditation also show beneficial effects. Health practitioners agree on the following strategies for CVD prevention and management:

- Removing saturated and trans fats from the diet and substituting monounsaturated and polyunsaturated fats
- Eating a diet high in fruits, vegetables, nuts, and whole grains, and low in refined grains
- Consuming omega-3 fatty acids from fish oil or plant sources
- Avoiding excessive salt and sugar intake
- Keeping blood pressure below 140/90 mm Hg (ideally less than 120/80 mm Hg)
- Keeping low cholesterol and triglyceride levels
- Exercising for at least 30 minutes (moderate intensity) on most days of the week
- Achieving and maintaining a healthy weight
- Not smoking; drinking in moderation

Sangeeta Singg

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Caregiver Stress

Every day millions of Americans serve as caregivers, providing unpaid assistance to family members or friends who are in some way incapacitated and need help with the activities of daily life. Caregiving can have many rewards, but it can also be a significant source of stress for the many caregivers who provide care, often at great personal sacrifice to their own physical, emotional, social, and financial well-being.

Caregiver stress has been studied extensively and negative consequences of caregiving have been clearly documented; nevertheless, researchers find significant variability in how caregivers adapt over time to the demands of caregiving. This variability can be attributed to numerous factors. The relationship history between caregivers and care recipients can be grounded in respect and love, or anger and resentment, each resulting in different emotional reactions by the caregiver to the demands of caregiving. Additionally, disability and disease characteristics vary significantly from one care recipient to another, placing unique demands on caregivers. Caring for elders with dementia, for example, is found to be generally more physically, emotionally, and socially stressful than caring for elders who are simply physically frail. Those living with the care recipient often report greater stress than those who don't, and the intensity and duration of care provided also are important determinants of stress. Those who provide care the longest and with the greatest number of responsibilities generally report feeling the most stressed. Finally, the meaning that caregivers assign to the demands of caregiving and their perception of how well they can cope with those demands play a critical role in influencing stress levels. The actual demands of caregiving may be less important than the caregiver's reaction to them and the coping resources, both internal and external, that the caregiver believes he or she has available.

Just as the demands of caregiving are multifaceted, so too are the stress-related consequences of providing care. Many caregivers report that over time, the demands of caregiving take their toll physically, emotionally, socially, and financially.

Physical Consequences of Caregiving

Numerous researchers have found caregivers to be at an increased risk of physical illness and premature death compared to noncaregivers. One study found that elderly spousal caregivers who reported experiencing high levels of stress were 63% more likely to die earlier than control subjects. Researchers have also established that in general, stress affects one's health by increasing blood pressure, suppressing the immune system, delaying wound healing, increasing cardiovascular risk, increasing levels of stress hormones, and prematurely aging cells.

Specific to caregiver stress, Ohio State University researchers found levels of interleukin-6 (IL-6), a substance that plays a role in immune system regulation, to be four times higher among Alzheimer's caregivers than noncaregivers. Not only were IL-6 levels significantly elevated, but the levels remained elevated for years, even after caregiving responsibilities had ended. These findings are important, because excess IL-6 is related to various health threats, including, for example, increased levels of

C-reactive protein (CRP), a risk factor for cardiovascular disease. Additionally, elevated levels of both CRP and IL-6 are related to arthritis, diabetes, congestive heart failure, and osteoporosis, diseases that significantly reduce one's quality of life and can increase the risk of early mortality.

In a seminal study exploring the relationship between stress and cellular aging, researchers at the University of California, San Francisco, found that stress prematurely ages cells by shortening the telomeres that cap the ends of chromosomes. Stress was also found to increase oxidative stress and lower levels of telomerase, a cellular enzyme that protects telomeres from breakdown and normally protects cells from premature aging.

The researchers compared mothers who cared for chronically ill children to mothers of healthy children and found that mothers in both groups who reported high perceived stress showed cellular signs of premature aging. Among the caregiver group specifically, the longer the mothers provided care and the more stressful they perceived their caregiving, the higher their oxidative stress, the lower their levels of telomerase, and most importantly, the shorter their telomeres. Additionally, the chromosomes in the white blood cells belonging to mothers who viewed their caregiving responsibilities as most stressful had aged the equivalent of 9 to 17 years more than the mothers who viewed caregiving as less stressful. Finally, the women who provided care the longest, regardless of their perceived stress, had the shortest telomeres of all. The implications of this research are significant because telomere shortening is strongly associated with reduced life span.

In summary, chronic stress related to caregiving can result in a reduced life span, premature cellular aging, or serious physical health consequences that can last for years after the caregiving responsibilities end. At greatest risk may be those caregivers who perceive their caregiving role as most stressful and who provide care the longest, such as spousal caregivers of Alzheimer's victims and special-needs children, many of whom provide care in excess of 100 hours per week for many years. Additionally, among elderly and/or physically vulnerable caregivers, the strain of caregiving can exhaust their already limited physical resources and exacerbate existing medical conditions. Finally, in addition to the physical risks associated with caregiver stress, some caregivers suffer even greater physical consequences because they develop negative coping behaviors such as unhealthy eating habits, not exercising, getting too little sleep, smoking, and abusing alcohol.

Emotional Consequences of Caregiving

In addition to the potential for harmful physical consequences when providing care, caregiving may also take a significant toll on the emotional health of caregivers. A substantial body of research shows that family caregivers are significantly more vulnerable to depression and anxiety than noncaregivers. In fact, depression is often cited as the most pressing concern for caregivers. Many studies of Alzheimer's caregivers have found rates of depression between 43% and 46%, with spousal and female caregivers reporting the greatest depression and one third of adult children showing signs of clinical depression after 1 year of caregiving. These high rates of caregiver depression are disturbing because depression can permanently alter the body's immune system.

Some researchers report emotional stress ratings that range from 4 to 5 (on a 5-point scale, with 5 representing the highest possible emotional stress) among those who provide care for 40 hours per week or more. Anxiety is also a concern for at least one third of caregivers. Irritability, anger, loss of self-esteem, guilt, despair over watching a loved one suffer, grief, and complete emotional exhaustion are also commonly reported emotional responses to caregiver stress.

Social Consequences of Caregiving

Studies have long shown a positive relationship between a strong social support network and reduced levels of stress, and access to a good social support network can buffer many of the physical and emotional consequences of caregiving. Unfortunately, over half of all caregivers report having less time for family and friends since assuming their caregiving responsibilities. Caregivers often report feeling socially isolated because, as they become less physically and emotionally available for others, their social lives become increasingly

constricted. Friends and family may not fully appreciate the sometimes all-consuming nature of the demands placed on the caregiver and may feel that the caregiver simply doesn't want to make time for them. This is often the case when caregivers provide assistance for a loved one with dementia. Those who have never encountered dementia firsthand may assume that since the care recipient looks healthy, he or she cannot possibly require extensive care. Others may drift away and stop visiting out of disinterest with the challenges the caregiver faces, or because of embarrassment about not knowing what to say to the caregiver or how to act around the care recipient.

Some caregivers may also push potential offers of support away because they feel that nobody else can provide adequate care for their loved one, or they believe they should be able to do everything themselves. Asking for and accepting help is seen as an imposition, weakness, or failure. Because of this strong sense of responsibility for meeting all of the care recipient's needs, the caregiver sacrifices both a personal life and a social life. The caregiver's interactions become increasingly confined primarily to the dependent relative, often when they most need the support of their friends and family. At that point, the social cost of caregiving may take an exhaustive toll on the caregiver.

Financial and Occupational Consequences of Caregiving

The financial and occupational consequences of caregiving can also be significant. Employed caregivers may suffer losses in career advancement, salary, and retirement income as a result of the demands of caregiving. Several nationwide studies have found caregivers in the United States earn less than the national median income and most provide at least $200 of financial assistance monthly to meet the needs of the care recipient.

Additionally, many caregivers struggle to manage the often competing demands of their caregiving and occupational roles. Sixty percent of caregivers work full-time or part-time while providing care for their loved one, and many feel that caregiving responsibilities negatively affect their work. Several large studies have found that nearly 60% of caregivers report going into work late, leaving early, or taking time off to provide care. Additionally, about 17% of caregivers take a leave of absence, 10% shift from full-time to part-time work, 4% turn down promotions, and 3% retire early. It has been reported that nearly half of parents caring for children with mental health disorders must leave the workforce at some time due to the demands of caregiving, and 27% are fired because of caregiving demands. Overall, roughly 6% of all family caregivers quit working because of the conflicting demands of their jobs and caregiving.

Finally, some experts estimate that American caregivers can lose up to $651,000 in wages, pensions, social security, and other benefits over their lifetime. Clearly, the financial and occupational hardships that caregivers face pose a significant source of stress.

Coping With Caregiver Stress

Coping with caregiver stress is an ongoing process, and at various points in time different features of the care recipient's condition will precipitate new challenges and adjustments. Thus, coping methods will necessarily change as the care recipient's needs change. Further, just as the demands and consequences of caregiving are multifaceted, so too are caregiver coping skills. Caregivers report relying on prayer, talking with or seeking advice from family and friends, reading about caregiving, exercising, seeking information on the Internet, talking with a professional or spiritual counselor, or taking medication when appropriate, as in the case of the caregiver who develops severe depression or anxiety.

Seeking out support, learning about and utilizing community resources, and engaging in personal self-nurturing are essential to managing caregiver stress. Ultimately, coping with caregiver stress can be reduced to one basic underlying challenge: the juggling act of balancing the caregiver's needs with those of the care recipient. Even high levels of caregiver stress can be buffered by adequate self-care and support.

Brenda Moretta Guerrero

See also Acute and Chronic Diseases; Aging, the Elderly, and Death; Alzheimer's Disease; Caregiving; Terminal Care

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Caregiving

In its most general meaning, caregiving is the providing of what is needed. *Caregiving* is used both as a noun and as a verb. As a noun, it refers to the organization of health care. As a verb, caregiving refers to both "taking care of," which means that one's specific needs are met, and "taking care for," which means that needs are met with feeling, motivation, and engagement. Caregiving is relevant for the issue of dying because it helps people to die in peace and with dignity. Since engagement is believed to be the heart of caregiving, care for the dying is particularly characterized by the care for the emotional impact that imminent death has on the one who dies. Various ideals of care for the emotional impact of death have affected the practices of care for the dying. To explore the ideals of care for the emotional impact of death, a sketch of its ideological development is presented. From there, three main issues in contemporary care for the emotional impact of death are explored.

Ideals of Care for the Emotional Impact of Death

Consolation for Mortality

In ancient Greece, the ideal of care for the emotional impact of death is particularly reflected in the consolation literature. The main aim of this literature is to achieve inner-world happiness in spite of one's mortality. Consolation is provided through a reflected meditation on the place of death in the cosmic order, the immortality of the soul, and the intangibleness of death itself. For example, arguments are presented about the limited meaning of death, about the fact that we all share in our mortal human condition, and about the pointlessness of grieving, for it doesn't help us any further. Care for the emotional impact of death is thus mainly directed at a consolation for human mortality.

The consolation ideal of care for the emotional impact of death is mainly found in Stoicism and (neo)-Platonism. Both movements believed that a virtuous directedness of the soul, in combination with a renunciation of one's attachment to life, console for one's mortality. Although many texts in Greek philosophy provide consolation, Krantor of Solio (ca. 330–268 B.C.E.), Cicero (106–43 B.C.E.), Seneca (4 BC–65 C.E.), and Plutarch (ca. 46–120 C.E.) are the most important representatives of this genre. At the basis of the consolation literature lies the conviction that feelings should be guided by reason. The ideal of this care for the emotional impact of death is to diminish and control one's grief rather than to suppress one's emotions.

Preparation for Afterlife

During the Middle Ages, the consolation ideal for the emotional impact of death is complemented by the Christian value of suffering. Through the resurrection of Christ, death is no longer the end of everything but becomes the step to a transcendent reality. Suffering is no longer accepted just because of its place in the order of things, but also for its purifying effect on humans' sinfulness. Besides heaven and hell as possible places for the afterlife, interest is increasingly paid to purgatory where the soul awaits its final judgment. The church teaches the remission of sins through praying, penance, and indulgences. The ideal of care for the emotional impact of death thus becomes directed at the preparation for the afterlife before God's final judgment.

The preparation ideal of care for the emotional impact of death did not conflict with the consolation ideal of the Greeks. Minucius Felix (2nd century), Tertullian (d. after 220 C.E.), and Lactantius (d. ca. 330 C.E.) elaborated upon stoic thoughts. Boethius (480–524 C.E.) famously integrated the care as a consolation for mortality with the care as a preparation for the afterlife. Christian consolation texts are written by St. Paul (d. 67 C.E.), St. Cyprianus (d. 258 C.E.), St. Basil (329–379), St. Gregory (332–400), and St. Ambrose (ca. 337–397). A late medieval and popular work on care for the emotional impact of dying is the *Ars moriendi*. This work consoles the dying, warns the terminally ill about wrong mental attitudes, and shows how one should pray and communicate with the dying in order to prepare them for the afterlife.

Humanization of Death

From the Renaissance onward, the preparation ideal for the emotional impact of death becomes criticized. Reformation thinkers, such as Luther (1483–1546), reject the church dogma on the existence of a purgatory and thus the possibility of repentance after death. For them, one's faith in the moment of death becomes crucial. This led to a focus on the death scene in which the last words of the dying were thought to be indicative of the quality of the transition to the afterlife. Humanists, such as Erasmus (1466–1536), claim that Christ, and not the church, is the mediator between man and God. For them, man has his own responsibility in defining death. The ideal of care for the emotional impact of death thus becomes humanized, for it addresses the human capacity to assign meaning to death.

The humanization of death appears in the texts of various influential authors. For example, Hume (1711–1776) justifies suicide in the case when life becomes unbearable due to sickness, misfortune, and old age. Schleiermacher (1768–1834) adds to the orthodox and mechanistic otherworldly consolations the human urge to love each other for we always live in the face of death, and James (1842–1910) opens new perspectives on personal spirituality and immortality. The growing diversity of the meanings of death thus differentiated the ideal of care for the emotional impact of death various sub-ideals—varying from providing consolation, stimulating penance, bringing about faith, and exciting the experience of the sublime in nature.

Autonomy in Dying

From the late modernity onward, the growth of scientific understanding resulted in better hygiene, higher standards of living, and a longer average life span. Technological developments, such as artificial respiration, dialysis, and penicillin, opened the way to increasing control and postponement of death. The ideal of a care for the emotional impact of death became both disregarded and depersonalized. Terminal care often remained unorganized, and the imminence of death was generally not communicated to the dying. In reaction to these developments, doubt arose about the appropriateness of endless treatments, and new settings for dying—such as hospice and palliative care—arose. Focusing on the individual needs of the dying person, the ideal of care for the emotional impact of death becomes directed at the autonomy in dying.

The primacy of autonomy—together with technological progress, secularization, and inner ways of spirituality—forms the context in which present-day caregivers take care for the emotional impact of death. Although the concept of autonomy only becomes relevant from the 1960s onward, its meaning has been developed since the 18th century. For example, for Kant (1742–1804) autonomy

means to act out of free will in accordance with the objective moral law; Mill (1806–1873) sees autonomy as the subjective freedom of choice between options; and Sartre (1905–1980) defines autonomy as an identification and engagement with oneself. These differences have significant implications for the current ideal of care for the emotional impact of death. Three of these implications are discussed in the following section.

Implications of the Primacy of Autonomy

Finding the Right Moment to Die

Due to the primacy of autonomy, the suffering inherent to dying is increasingly understood as meaningless suffering. Living in a society where chronic illness is the main cause of death, the elderly are increasingly subjected to physical and psychic limitations. Many of them face a slow but certain loss of autonomy, control, and independence. Due to the fragmentation and weakening of religious meanings of death, this loss of autonomy in the dying process is increasingly defined as unbearable, hopeless, and degrading. As a consequence, old people increasingly prepare for a death without suffering.

The number of old people who commit suicide is increasing, as is the number of people who arrange advance directives in which they settle abstention or termination of treatment in the event they should be unable to give informed consent. Termination of treatment in the case of irreversible coma or persistent vegetative state is heavily debated on the basis of what the patient would have decided. Although few countries have legalized voluntary euthanasia and physician-assisted suicide, many countries face problems in dealing with these issues. These developments show that individual control of when and how one wants to die has become part of the Western context of dying. The ideal of care for the emotional impact of death thus increasingly implies care for what is considered to be the right moment to die.

Finding Meaning in Dying

The primacy of autonomy changes the relationship between caregiver and the dying person. The dying expresses the need for help of others, decides what personal or spiritual path is to be taken, and gives meaning to death. The caregiver is sensitive to the wishes and emotional processes of the dying person and aims for adequate response. As long as this response is connected to the autonomy of the dying, adequate care is provided. However, the primacy of autonomy falls short when the dying is overwhelmed by the emotional impact of death. One-sided care based on autonomy then risks losing sight of its most important goal: to care for the emotional impact of dying in which one's autonomy is lost.

Care for the emotional impact of death is often a compromise between paternalism and respect for autonomy. Too much initiative may result in misplaced conversations about God and the afterlife or to premature advice. Too much respect for autonomy may result in letting a person die without adequate care for the emotional impact of death. Although various care ethicists have purported to resolve the dilemma by stressing the mutual relationship between caregiver and the dying person, the problem of autonomy in dying remains paramount. The ideal of care for the emotional impact of death thus increasingly implies care for the annihilation of one's autonomy.

Finding Engagement With Dying

The primacy of autonomy rejects rather than engages with the phenomenon of dying. The media mostly presents death without connecting to normal experiences of dying; in both public and private it is taboo to speak about death; and the societal focus on youthfulness and ambition disregards the vulnerability and finiteness of life. In health care, the focus on treatment leaves little space for the issue of dying; professionals are supposed not to overidentify with the dying; and when dying finally occurs it is mostly in hospitals and nursing homes, which support the dying and their families only to a limited extent. Care for the emotional impact of dying is thus embedded in a disappearing face of dying of Western culture.

Generally, engagement largely depends on identifiable mutuality of experiences—people feel closer or more sympathetic to others when they recognize their experiences. Because dying normally lacks such mutuality, it is extremely difficult for caregivers to understand what the emotional impact of

death is about. In order to know "when to do what" it is often suggested that caregivers themselves confront the notions of death and dying. Since society increasingly fails to provide the opportunity for such personal confrontations, caregivers lack general experiences with death and dying. Therefore, the ideal of care for the emotional impact of dying increasingly implies care for finding engagement with dying as such.

Eric J. Ettema

See also Art of Dying, The (*Ars Moriendi*); Caregiver Stress; Death Awareness Movement; Informed Consent; Right-to-Die Movement; Terminal Care

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Caskets and the Casket Industry

The term *casket*, sometimes denoted as *coffin*, refers to the container in which the dead are placed for burial. In the earliest times of humankind, simply wrapping the deceased and placing in a cave or burying in a shallow grave was considered sufficient. But as cultural rituals became more prominent, it became common to produce burial enclosures out of woven reeds, pieces of wood, pottery, or stone. The status of the family was important, as the costs and handling increased with the more elaborate designs and materials. Even simple burial vessels could be augmented with personal belongings of the deceased wrapped in cloth or put into small pottery; these belongings were considered a necessity for the soul of the deceased to carry to the spiritual world. As the use of wood and pottery became common, designs of faces, flowers, and earthly material holdings became a part of the ceremony prior to burial. Over time, improved technologies enhanced the craftsmanship involved in casket building and these provide the backdrop for the discussion in this entry.

The Art of Casket Making

The stone coffins were the most difficult and required stone masons/carvers to cut and decorate as desired. Moving and setting stone enclosures required teams of people and equipment to set in the burial site. Many early customs required that the body be "free to the sky" so the spirit could travel to its next destination. Even funeral pyres and cremation platforms included some kind of ceremonial wrap of the deceased and accompanying artifacts of the person's life.

Burial vessels were crafted and manufactured by hand until the 1900s when assembly lines began to be utilized by the larger manufacturers of caskets. Even the early lead, steel, and hardwood caskets were handmade products that could easily be custom fitted with colors, materials, and décor chosen by the family. The earliest wooden coffins were usually simple, and the church would provide various covers for them prior to burial for a more elaborate ceremony of the loved one's life. These mortuary cloths could provide religious symbols, colors, and habits of the deceased for the celebration, then be removed upon placing the coffin into the grave.

The early wood coffins were larger at the top to accommodate the shoulders and small at the bottom foot end. Some had windows above the head, so the deceased was viewable during the ritual showing prior to burial. At the beginning of the 19th century, this design became rectangular, which was easier to manufacture, as mass production became common. As the eight-sided coffins became less common and the six-sided caskets were in demand, the assembly line mass production process became more common.

It was in the mid-1800s that the first casketed steel casket was offered, but materials of the time made it difficult to use. Later, sealing materials and fasteners made the gasketed caskets more common. The seal on the casket was offered to stop elements of earth and moisture from entering the interior of the casket, while allowing the gases of decomposition to escape. As with the early pottery or stone enclosures, when metals became common in the manufacture of caskets, the status of the deceased could dictate the type of metal utilized, from copper and bronze with gold trim to the reduced costs of simple 20-gauge units with single colors. Social status has been tied to burial containers since the beginning of their use.

Modern assembly lines consist of conveyer belts and large metal or wood working machines that can process 100 to 1,000 caskets daily. Seam welders, power drivers, and powder paint booths make it possible to manufacture large numbers and higher-quality caskets than ever before. These modern assembly lines also provide the market with quick delivery, which is required due to the time element between death and burial. Instead of being limited to the units on display at any given funeral home, the family can now pick the casket material, color, fabric, and custom touches and expect delivery within days. The reason that burial rituals have become so elaborate and versatile may be, in part, because so many choices are available.

Casket use has become quite complicated when compared to its earliest beginning. One of the aspects of the various customs of contemporary societies is that the original simplistic wooden box continues to be used in a large part of the world. Many areas still prefer that the body of the deceased start the decomposition process as soon as possible and return to the earth quickly. Even today, many customs are to simply wrap or enclose the remains and bury soon after death. The custom of embalming was an option to allow transfer of remains back to their home of origin and to allow time for relatives to gather for the ceremony.

One of the critical periods of growth for embalming was the Civil War, during which so many soldiers died and were returned to their home areas for family ceremony and burial. This ritual was hand administered until 1920 when the first electric embalming machine was perfected and allowed quicker preparation of the body along with refrigeration to keep the condition acceptable for ceremonial showing and services. This process, along with the gasketed containers, provides an environment that can keep the remains intact for many years. This is very important due to modern transient society and the distances normally required when bringing the deceased and family back to a common area.

Laws Affecting the Industry

All funeral homes that handle and prepare the deceased are under state of location laws that require licensing for the funeral home employees who work with the families and deceased. Funeral home personnel must also adhere to strict continuing education requirements each year that keep them abreast of new equipment, chemicals, and handling and procedures for burial. Some states require that caskets be sold only by licensed funeral directors. Safety procedures for the embalming room and procedure are also constantly under scrutiny and must be renewed regularly. Cemetery and crematory regulations are also an important aspect of continuing education. State regulators make frequent visits to these facilities and inspect all operational aspects to confirm compliance. The stretchers, lifts, operating tables, tools, vehicles, and display platforms also require certain specifications so that every item is safe for use with various sizes of the deceased.

Contemporary Caskets

There are many choices of construction and materials available for caskets and each has inherent characteristics, advantages, and price points that are necessary to meet the needs of the customer interested in selection. The predominate manufacturing materials are steel, wood, composites, and cloth. The interiors include a multitude of fabrics available, including velvet, silk, crepe, satin, twill, cotton, and polyester. How we choose to honor our dead with their final vessel of viewing, transport, and burial thus follows.

Steel

This includes bronze, copper, stainless steel, 18-gauge steel gasketed, 16-gauge steel gasketed, 20-gauge steel gasketed, and 20-gauge steel

nongasketed. Bronze and copper are the top end materials used for caskets due to their precious metal status and ability to be brushed and finished with high appearance paints and lacquers. All of these units are furnished with gaskets that help protect the casket contents from the elements present after interment. They also have advanced closing mechanisms that assure as tight a seal as available utilizing the gaskets provided. The interiors are normally comprised of either silk or velvet. These caskets would fall into the highest cost category.

Stainless steel is the next level of protective material available, providing long-lasting life and normally gasketed to keep out elements after burial. Interiors are normally velvet or crepe. Finishes are smooth or brushed with natural stainless steel finish or high-quality paint finishes.

Prices are high to lower end high. The most popular casket in volume is the 18-gauge steel casket, due to its medium-level pricing. This casket is gasketed to provide protection from the elements after burial. Many finishes and colors are available as well as a multitude of interiors, including velvet, crepe, and velour. All of these caskets are supplied with support beds on which to place the deceased; most have adjustable height mechanisms to accommodate various size bodies. Matching interior fabrics, pillows, and decorative head panels in the casket lid come with the units. Depending on the needs of the area served, most caskets also are available in either "split lid," where the head-panel lid is opened only to display the deceased from waist to head, or "full couch," in which the entire lid of the casket is one piece to allow entire body display. When closed and ready for transport, the units are supplied with either swing bar handles that fold flat for display and are hinged for lifting the casket or fixed bar handles that are stationary. These caskets are also supplied with memorial tubes inserted in the end of the body of the casket or identification card kits inside so the deceased can be properly identified in case of identification upon disinterment or a tragic misplacement of the casket/body at a later date. Twenty-gauge caskets are the most affordable steel units and come in both gasketed and nongasketed constructions. The gasketed units have a larger choice of color finishes and interiors while the nongasket models have simple interiors and few options, thus providing lower costs when needed. The metal on the 20-gauge casket is thinner and weaker than the

Twenty-gauge metal casket with blue tremaine crepe interior and pleated head panel with capability of themed insert. Swing bar lifts for ceremonial transfer with decorative hardware and gasketed closure. Includes memorial tube for possible disinterment and available in multiple color combinations and for personalization.

Source: Aurora Casket.

other steels listed in this entry and are not recommended for heavier contents. Average-size bodies will fit and carry sufficiently. The nongasketed models will not keep elements from entering the casket body and hastening decomposition.

Wood

The finest hardwoods available are used to manufacture the mahogany and walnut caskets. These units are available in various shaped corners and finishes and are usually outfitted with velvet interiors. The wood grain is left visible, then stained and polished for exquisite presentation of the deceased. All are supplied with pillows and throw blankets to cover the bottom end of the body displayed. Cherry, oak, and maple are the next level price range, which is in the mid-expensive range. Velvet and crepe interiors are used with matching head panels, pillows, and throws. Swing bar handles are provided for ease of transport. All of the these hardwoods are quite heavy when occupied and require sufficient strength to carry. Gloss and semi-gloss finishes are available on most.

Pecan and hickory round out the hardwood caskets available and are stained with various color stains that bring out the significant grain in their appearance. Poplar, cedar, pine, and ash are also available and rate in the expensive to mid-expensive range of cost. Velvet, crepe, and satin interiors are used. Light pine, composite, and veneer units are also available for lower pricing levels and, though having a nice appearance, may not hold up as well after interment.

Cloth

The least expensive caskets are made of composite wood products or strengthened fiberboard and covered in decorative cloth finish. These units are designed for the lowest budget needs and should not be used for oversized or heavy bodies.

Cremation

Soft woods, pressed composite board, or cardboard are used in simple vessels to accommodate the deceased to the crematory.

Oversize

When larger bodies are prepared, it is sometimes necessary to utilize caskets with additional width to accommodate the deceased. These are available in oak, cherry, poplar, 18- and 20-gauge steel, and in numerous colors and finishes. The offering assortment grows annually with need. Prices are slightly higher than the normal-size caskets mentioned earlier in similar materials and finishes.

Unfinished basic pine casket with white satin interior and head panel also meets the needs of orthodox burial.

Source: Aurora Casket.

The casket industry is presently supplied by three major U.S. manufacturers, namely Batesville, Aurora, and York/Milso, as well as a multitude of smaller suppliers across the country. Caskets are starting to be supplied from Mexico and China and are impacting the overall price and quality expectations of funeral homes across the country. Cremation is also impacting the industry and growing yearly. This has opened a large market for cremation caskets and urns of various applications and cost. As society changes its customs and requirements, the industry will continue to support the various needs of families honoring their deceased.

Herbert Glaser

See also Body Disposition; Burial Laws; Cemeteries; Funeral Home; Funeral Industry

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Causes of Death, Contemporary

The cause of death is a short statement that informs a reader as to the reason for an individual's death. Strictly speaking, it should be divided into the medical cause of death, or a short statement of an illness or medical condition that was responsible for the death of the individual, and the manner of death, which is a legal conclusion on the circumstances of an individual's death. While this appears to be straightforward, for many physicians, lawyers, and ethicists, this can be the most difficult issue with which they must deal.

Historical Developments

Death was defined historically and by "common law" to be the condition whereby the circulation (heartbeat) as well as the breathing of an organism had stopped. This was easily understood by all and required no medical training. Even so, medical doctors were frequently asked to attend a death and confirm that these physiological events had occurred.

This determination of death became more complex and controversial when the World Medical Association, at its assembly in Sydney in 1968, introduced and adopted the concept of brain death. This concept can be further divided into that of brainstem death, as adopted in the United Kingdom, and that of whole brain death, as adopted in the United States in 1980 with the Uniform Determination of Death Act.

The medical cause of death can be as variable or colorful as the individual doctor writing the statement. François Bossier de Lacroix is credited as the first person to propose a systematic classification of disease in the treatise *Nosologica methodica*. The statistical study of diseases for practical purposes had a century earlier been exemplified by the work of John Gaunt on the London Bills of Mortality. William Farr, a medical statistician with the General Register Office of England and Wales, along with Marc d'Espine, is credited with developing the first internationally applicable and uniform classification of the causes of death. This led to the Bertillon Classification of Causes of Death in 1893, a classification that was later developed into the International List of Causes of Death. Successive revisions and lists were introduced.

In 1948, the World Health Organization prepared the two-volume *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death*. In 1955 and then in 1965 the seventh and eighth editions, respectively, were published. The ninth edition followed in 1975, and the tenth edition was first introduced in 1989. Modifications to the classifications continue, and several new versions of the tenth edition have been promoted.

Determination of the Cause of Death

Under ideal situations, the following would be the background for the determination of a cause of death statement. A trained, qualified physician will attend the death of an individual wherever this may be. This doctor will make determinations to establish the fact of death and will then decide on the medical cause of death. In doing this, available medical records and charts are reviewed to determine if a disease or disease condition caused the death. If this was possible, some form of document containing the name of the deceased

individual, the place of death, the time of death, and the medical cause of death can be issued, and this information can then be registered with a legal authority such as the registrar of death. Upon such registration, action can be taken to initiate funeral arrangements, death duties, and inheritance procedures.

However, many reasons exist for why a medical cause of death cannot be determined. The death may have occurred suddenly and unexpectedly, for example, and, in such a situation, there is no prior information of disease or poor health that may suggest a disease process. This is particularly true when a death occurs outside a hospital. Even when death occurs in a hospital, the death of the patient may happen so quickly that blood tests and X-rays have yet to be performed. Hence the clinician is without objective information to suggest a medical cause of death. In some circumstances where the medical cause of death is clear, the death will still have to be reported because the death was due to unnatural causes such as poisoning or traumatic injuries. When the death is due to unnatural causes, the death will then be reported to a medico-legal death investigative authority such as a coroner, a medical examiner, an investigating magistrate, or judge. This death will then be investigated through detailed examination of medical history, medical illness, circumstances of death, and postmortem tests, including postmortem examination of the body. Only after such a review can the medical cause of death and the manner of death be determined.

A postmortem examination may be required to establish the cause of death. However, research has found that the autopsy rate in the United States falls below 10% (to nearly 5%) when unnatural deaths such as accidents, homicides, and suicides are excluded. Moreover, the autopsy rates for the elderly and for certain diseases, such as cerebrovascular diseases, are particularly low. Despite the efforts of the College of American Pathologists, which strongly advocate autopsies, the decline in the autopsy rate in the United States continues.

This phenomenon is not unique to the United States. In many countries around the world, the number of autopsies performed is decreasing to such an extent that they are no longer a part of the experience for medical students. Indeed, in Australia and Hong Kong, trainee hospital pathologists are finding it difficult to gain adequate experience in performing the number of autopsies required to demonstrate their clinical competence.

In Switzerland, postmortem examinations are now being replaced by postmortem full body CT (computer tomography) and MRI (magnetic resonance imaging) scans. In autopsy rooms, CT scanners are being installed and less-conventional autopsies performed. This declining trend for conventional autopsies can be easily explained. The general public has never embraced autopsies. The autopsy is still viewed as a gruesome, disfiguring, and destructive procedure. The development of better and more imaging technologies have led to the assumption held by many individuals that the autopsy is redundant because everything inside the patient can now be seen. Health authorities in general are not overly enthusiastic about building better and safer autopsy rooms because of costs and, perhaps also, because the autopsy findings more often than not lead to compensation payouts for wrong diagnoses.

The Politics of Death Investigation

The cause of death statement is ideally an exhaustive and scientific analysis of all relevant medical information to arrive at a learned conclusion. Such cause-of-death data, when gathered systematically, can allow epidemiologist and health policymakers to understand the burden of diseases in their community and to target prevention strategies and health care resources.

Cause-of-death data are used to inform national statistics as well as to allow international comparisons. The *International Classification of Diseases* (ICD) has gone through many versions since 1946, and the current *ICD-10*, first introduced in 1989 and last updated in 2007, is the common tool used by the World Health Organization (WHO) to study world health and disease burden.

The adoption of the ICD system theoretically allows WHO to monitor the state of health of the world population and to develop strategies specific to regions and countries. At present WHO has 228 member states reporting to its ICD system. This provides a broad range and wide coverage of countries in the various regions of the globe and involves well-developed as well as underdeveloped countries.

The reality, however, is that many countries are not using any ICD codes or are using older versions of the ICD codes. These countries often do not have adequate health care systems and are most in need of help. Yet, ironically, because of the absence of data, little is known and aid is often not forthcoming.

Death reporting systems require a stable legal system. Countries in political turmoil or in a state of anarchy and lawlessness are unable to gather and register such information, and here again the absence of information will also lead to less international understanding and less aid.

The politics of death registration can also be seen locally; regimes may wish to manipulate data on causes of death. Increasing reports may attract attention and resources for specific research areas or projects and are hence encouraged. Conversely, increasing reports of an infectious disease may cause alarm among incoming tourists on occasion, leading authorities to suppress such information. Even at the individual case level, the politics of death registration can have a profound impact on individual lives and communities. In such situations, the issues usually revolve around the uncertainties of death determination, causation of death, and manner of death.

Declining Autopsies

It is obvious that the ideal determination of death does not exist in all areas of the globe. Even in developed countries where the medical and legal systems are in place and the possibility of obtaining accurate cause of death data is better than in lesser-developed countries, most experts argue that there is at least a 15% error rate. This stems from an inherent error in determining the cause of death in cases where no autopsies are performed. A continuing decline in autopsy rates worldwide creates an even greater concern over the accuracy of the cause of death data.

The Cause of Death Classification

An area of error lies in the actual process of writing a cause of death. Even in developed countries with structured and controlled systems of medical education and training, there is inadequate instruction on how to determine a cause of death. It is therefore common to find mistakes in the cause of death statement found on issued death certificates. Such mistakes should ideally be noticed by registrars of deaths who can notify the doctors concerned to have the mistake corrected. However, this process of counter-check is rare and seldom systematically applied.

Another limitation of the current system is that it allows effectively only one underlying cause of death. In many developed countries with aging population, death may be the result of a combination of degenerative diseases and failing organ systems. Thus their representation will often be underreported. Emerging diseases, such as the severe acute respiratory syndrome (SARS) in 2003, can cause confusion as they may be coded in a variety of different ways and lead to underreporting of the actual burden of the epidemic. In Hong Kong, where nearly 300 persons were reported to have died from this condition, the causes of death issued varied from pneumonia, to adult respiratory distress syndrome, to SARS, to corona viral infection.

In rural communities and in underdeveloped countries, the basic requirements of trained medical and legal personnel are often absent. It is, therefore, not surprising that the cause of death statement would not conform to those expected by the ICD system. Even where they do conform, the basis of such a conclusion is open to doubt.

Despite these limitations, the ICD system for gathering data on cause of death of the world's population is still a worthwhile endeavor that generates useful and important epidemiological data that can guide prevention policies and focus prevention programs. Recent publications of data and reports from WHO have included information on the reliability of the data, data collection systems, as well as an indication of the sophistication of the data-gathering infrastructure available in each individual country.

Manner of Death and Equivocal Death

In many jurisdictions, the cause of death statement will be followed by a legalistic conclusion of the manner of death. Manner of death is a simple form of classification of all deaths into one of the following: natural cause, accident, suicide, homicide, and undetermined. This delineation allows

epidemiologists and researchers to focus on specific types of deaths that they may be interested in. For example, changes in the pattern of deaths due to traffic accidents may lead to studies by car manufacturers and road designers to improve safety as well as efforts to modify dangerous driver behaviors such as speeding or driving under the influence of alcohol or drugs through education efforts as well as regulations and penalties for offenders. Deaths by suicide may inform on the state of mental health and the provision of mental health treatment in a community. It may also be useful for determining the presence of social ills and welfare needs in a community.

The determination of the manner of death is an "official" pronouncement; as such, it can have far-reaching consequences and effects on the surviving family members of the deceased, on the estate of the deceased, on the insurance claim and payout, and, perhaps more importantly, on the reputation of the deceased and his or her family. To illustrate this, consider the death of a person by hanging. Instinctively, one would be inclined to suggest that the manner of death was suicide. However, this determination can only be made if a full investigation has excluded sexual misadventure or homicide by suffocation or by intoxicating agents staged as a hanging death. Investigation of the scene of death is crucial in such cases; the manner of death may not be thought of as a suicide if sexual aids, bondage, and restraint equipment were found to have been used. Here, the possibility of an accidental death due to sexual asphyxia during sexual play or experimentation would perhaps be a more accurate assessment and conclusion of the manner of death.

Families frequently find the suggestion that death was a result of sexual asphyxia unacceptable. Such a manner of death determination often will be legally challenged. A finding of suicide to appease the family would be incorrect and can lead to prolonged civil action from insurers. In other cases, the impact of religion may also be a strong determinant for objection to the manner of death if labeled as suicide. Even a finding of natural death can result in prolonged angst for the family, if they believe that death was a result of a medical mistake or negligent care. Declarations of homicides too are not immune to challenge as they may lead to accusations of official persecution or outcries of failures of the law enforcement agencies.

Despite such issues, determination of the manner of death is generally straightforward. In many jurisdictions such determination is made by the coroner or medical examiner or perhaps an investigating magistrate. In the coroner's system that exists throughout the British Commonwealth countries, a jury is convened for assistance in determining more difficult cases as an aid to the coroner.

Changing Trends in the Causes of Death

The ICD system provides policymakers, health practitioners, and scholars with reasonably reliable information on changes in patterns of diseases within a country or within regions of the world. WHO data for the year 2007, for example, show that the causes of death are very different between countries that are developed, developing, and underdeveloped. The leading cause of death for countries with high per-capita incomes, such as the United States, is coronary heart disease. Other lifestyle-related diseases in the top 10 list for 2007 include chronic obstructive airway diseases, stroke and cerebrovascular diseases, and diabetes mellitus. Cancers of the lung, breast, colon, and stomach also were in the top 10 lists. In countries with low per-capita income, the leading cause of death is also coronary heart disease. However, infectious diseases such as HIV/AIDS, malaria, tuberculosis, and diarrheal diseases are among the top 10 causes of death. Perinatal conditions and road traffic accidents also are among the top 10 causes of death in countries with low per-capita income.

When studied over time the top 10 causes of death offer a unique view of developing trends, suggesting the need for health care resources in different communities. The trend appears to suggest that lifestyle-related diseases are affecting even the low-income countries, where the effects of a modern idle lifestyle is quickly catching on. Similarly, the prevalence of traffic fatalities reflects inadequate attention to good roads, well-maintained vehicles, and driver and pedestrian awareness of the dangers of their actions. The clear absence of infectious diseases in the list for countries with high income clearly illustrates the need to make resources available for the treatment of infectious diseases, as they are so infinitely preventable.

Finally, the study of lists within a country also can provide a good overview of the successes or failures of health care policies. Data from the U.S. National Vital Statistics Reports showed that the top 15 causes of death in the period from 1999 to 2005 have remained the same with the exception of a change in position between homicide and Parkinson's disease. However, the actual rates of death by homicide have gradually risen from 6.1 deaths per 100,000 population to 7.3 deaths per 100,000 population.

During this same period the death rate from heart diseases decreased from 259.9 per 100,000 population to a figure of 220 per 100,000 population. Some decrease in deaths resulting from malignant cancer also can be observed with the rate declining from 197 to 188.7 per 100,000.

The rise in accidental deaths provides a more somber conclusion for the increases recorded in the number of deaths due to accidents. Deaths associated with Alzheimer's disease also increased from 16 per 100,000 to 24.2 per 100,000, an almost 50% increase in the 7-year period. Such vicissitudes in the nature of death-related data are suggestive of important dynamics. Hence, cause-of-death data, although subject to complex systemic problems and recording procedures, provide a holistic perspective and assist in directing future attention to emerging areas of public health concern.

Philip Beh

See also Coroner; Coroner's Jury; Medical Examiner; Mortality Rates, Global; Mortality Rates, U.S.

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Causes of Death, Historical Perspectives

Through time there have been significant changes in the major causes of death for human populations. The major causes of death have changed from infectious and parasitic diseases to chronic conditions, such as heart disease and stroke. Numerous factors have influenced the changing causes of death, including nutrition and diet, personal hygiene, exposure to new environments or contagions, public health measures, changing perceptions of the causes of disease and illnesses, and medical advances and discoveries. With the historical changes in causes of death has come an increase in average life expectancy, particularly during the 20th century.

This entry outlines some of the major historical trends in causes of death, primarily for the United States, as well as the factors that are associated with such changes. The first section discusses the sources of data available to conduct a historical study of causes of death. The next three sections examine major causes of death during the colonial period, the 19th century, and the 20th century. The final section examines early 21st-century trends with a view toward future causes of death.

Data Sources and Data Quality

Records of death rates, causes, and differentials are limited in coverage for the United States before the late 1800s. Thus, information about mortality trends from colonial times until the mid-19th century is based upon data collected in smaller geographic units, such as cities or reporting states. Much of the early information about deaths was derived from personal journals, diaries and letters, newspaper accounts, or other public records. Deaths were not regularly reported or recorded in all areas, and this was particularly true of infant and child deaths. Church records and family histories can provide information about births, marriages, and deaths; however, much of the information is missing, somewhat inaccurate or incomplete (such as infant deaths occurring before baptism), or not analyzed in a systematic fashion.

The decennial census, beginning in 1790, established an important source of demographic data.

However, mortality information was not collected in the census until the mid-1800s, and the information was not consistently recorded in the public record. Individual states and the federal government were slow to develop vital registration systems to record demographic events, such as marriages, births, and deaths. In 1900, the federal government began publishing annual mortality statistics, based upon the newly established death registration system. The initial death registration area included 10 states, the District of Columbia, plus 153 cities not in the death registration states. Through the years additional states were included, and by 1933 the death registration system covered all of the United States.

Colonial Period Mortality Trends, 1600–1800

During the colonial period the major causes of death were primarily infectious diseases. Regional differences in death rates across colonial America were due to differences in rates of disease transmission and survival, immunity to disease, and the methods used to treat or prevent the spread of disease.

From 1600 through 1775 smallpox was a major cause of death in Europe and North America. A highly communicable viral disease, the smallpox virus typically is passed from host to host, but it also can remain infectious for months on inanimate objects, including bedding and clothing. Once infected, the person either dies or survives with a long period of immunity. In the urban areas of the Old World—Europe, Asia, and Africa—children were most likely to contract smallpox, and thus, adults were typically immune to the disease. Smallpox was brought to the New World from Britain and the West Indies, and outbreaks were highest in the port settlements, such as Charleston, South Carolina, and Boston, Massachusetts, where new immigrants arrived. Because the arrival of trade and passenger ships was not on a regular schedule, the outbreaks of smallpox were erratic. The periodic smallpox epidemic affected all ages, because the adults living in the colonies were less likely to be immune.

The smallpox death rate was lower in colonial America compared with that of Britain. A factor contributing to the lower colonial death rate was the introduction in 1720 of variolation. An early form of inoculation, variolation was the application of pus of an infected person to an incision in a healthy person who contracted a mild form of the infection, in turn building immunity against the deadly smallpox.

Another infectious disease that affected the colonists in coastal regions was yellow fever. Originating in Africa, the disease is spread by mosquitoes thought to have bred in water barrels on slave ships arriving in the Americas. The first outbreak of yellow fever is thought to have occurred in Boston in 1693 imported by a British ship from Barbados. Then, during the 1700s, yellow fever emerged in New York, Philadelphia, and Charleston on several occasions; New Orleans experienced an initial outbreak in 1796.

Yellow fever represented a puzzling disease because infected colonists who moved to new locations did not spread the disease, and the disease inexplicably disappeared during cooler months, particularly in the northern regions. The relationship between mosquitoes and the transmission of diseases such as yellow fever was speculated; however, the causal relationship was not verified until the end of the 1800s. Other infectious and contagious disease endemics during the colonial period included malaria and dysentery. Respiratory diseases such as pneumonia, influenza, and respiratory infections, as well as typhoid fever, typhus, diphtheria, scarlet fever, measles, whooping cough, mumps, and venereal disease had an effect upon the death rate.

Other causes of death were the result of infection associated with cuts, amputations, and other medical treatments during colonial times. Death also occurred due to the lack of adaptation to a new environment. It is estimated that in the southern colonies during the 1600s as many as 40% of the new arrivals did not survive the first year.

Native American Mortality Trends

Few serious epidemic diseases were evident in North America before European settlement. One reason is the fact that there were no large dense population centers to transmit and sustain epidemic diseases. Another reason was that Native Americans had fewer domesticated animals; thus it was less likely for infectious or contagious diseases to transfer from animals to humans. A number of

Old World contagious diseases can be traced to this animal-to-human transmission.

Before European colonization Native American deaths were caused by famine and nutritional deficiencies, warfare, parasites, and infectious or contagious diseases such as tuberculosis, influenza, and syphilis. The arrival of ships from the Old World brought new diseases to which the Native Americans had never been exposed, including smallpox, typhoid, diphtheria, scarlet fever, whooping cough, pneumonia, malaria, and yellow fever. The Native American populations were decimated by the introduction of these new diseases, particularly during the 16th and 17th centuries.

Colonial Response to Infectious Disease Epidemics

Epidemics were frequent and disruptive to life in general. Public offices were closed or meetings were moved to areas outside the affected urban centers. Colonial laws were enacted to quarantine persons with contagious diseases for periods of 10 to 12 days for newly arrived ships to monitor for potential diseased passengers. Residents who were infected with contagious diseases were required to be quarantined at home or in establishments such as "pest houses" to be isolated from the general population. Many persons felt infectious and epidemic diseases were God's punishment for sinful ways, and it was not uncommon for public and/or religious officials to call for a period of prayer and fasting to appeal to God's grace to stop the further spread of disease and death.

New England had the lowest death rates and the South had the highest. The mid-Atlantic colonies had death rates similar to those in New England. The lower death rates in New England were due to the development and enforcement of strict quarantine laws, which reduced the spread of disease. The higher death rates in the South were due to the warmer environment, which was a breeding ground for mosquito-borne diseases, plus the arrival of larger numbers of immigrants who were not quarantined.

Colonial War Casualties and Deaths

Wars have been fought on American soil and there have been deaths on the battlefield as well as noncombat deaths to service members. It has been estimated that only 2% of the war deaths during the American Revolution were due to battle casualties. Hundreds of soldiers died of smallpox in the early years of the warfare so General Washington and others insisted that new recruits be inoculated; the inoculations reduced smallpox deaths. Filthy encampments, inadequate or unsafe food and water, and lack of immunity resulted in many soldier deaths due to infectious and contagious diseases such as typhus fever, dysentery, and pneumonia.

19th-Century Mortality Trends, 1800–1900

Infectious and contagious diseases continued to be the major causes of death during the 19th century. Smallpox was less of a threat due to the discovery by Edward Jenner in the late 1700s, which encouraged the use of safe cowpox virus vaccinations. But yellow fever continued to be a threat during the warm summer months, and periodically it reached epidemic proportions. Other infectious diseases such as typhus, typhoid fever, scarlet fever, and tuberculosis also were major causes of death.

The first cholera epidemic occurred in 1832, brought by immigrants from England. Cholera is caused by bacteria that are spread through feces-contaminated water and food. The filth and poor public sanitation, particularly in urban areas, caused cholera epidemics to occur from 1832 to 1873.

Death Rates During the 19th Century

Historical genealogical records and death registration systems are useful to approximate the increase in death rates during the 1840s and 1850s. With enhanced transportation technology during the 1800 to 1860 period, increased migration, and greater trade opportunities across the country, cities became larger and more densely populated, jobs shifted from farms to factories, and public school opportunities expanded. Such changes resulted in increased contact among people and increased human exposure to infectious and contagious diseases.

A number of the infectious diseases negatively affected the nutritional status of children, which meant that affected children did not grow and develop at normal levels. Nutritional deficiencies

and delayed growth and development during childhood also resulted in lower average weight and height during adulthood. Military medical records indicate that there was a decline in average height for men born during the 1820s until the latter part of the late 19th century. The records also indicate social class differences in height existed among Union soldiers from the Civil War era. Laborers measured the lowest heights while farmers had the greatest height advantage. By the end of the 19th century there is evidence of social class differences in mortality rates, with persons in the professional occupations having the lowest death rates while the highest death rates were recorded among laborers and servants.

The Civil War was the most deadly in terms of battle casualties. It has been estimated that 6.3% of the Union soldiers and 7.1% of the Confederate soldiers died in combat. Infectious and contagious diseases also added to war casualties due to unsanitary conditions, inadequate food and clothing, and lack of immunity, which resulted in deaths from intestinal disorders, respiratory diseases, and other diseases such as measles and tuberculosis, particularly for Confederate soldiers.

After the Civil War, death rates decreased due to an enhanced standard of living that included improved diet and more adequate shelter as well as improvements in public health. In 1854, John Snow identified a public water pump to be the source of an epidemic of cholera in the city of London. Later discoveries about bacteria and other sources of contamination led to the important introduction of water filtration systems and the addition of chemicals into the water to destroy bacteria. Public works and public health reforms led innovations such as in Boston and New York City where aqueducts for piping fresh water were built prior to the Civil War. By the end of the 19th century many urban areas had established such public works programs. The result was a lowered rate of death in urban areas.

20th-Century Mortality Trends, 1900–2000

The advent of the 20th century was witness to dramatic improvements in death rates. In 1900, the crude death rate, which is the number of deaths per 100,000 persons, was 1,719. By 2000, the crude death rate had decreased to 874 deaths per 100,000 persons. However, there were events that occurred to affect the still high death rate. The 1918 worldwide influenza pandemic, for example, has been compared with the black plague of the 14th century in terms of human lives lost, resulting in the anomalous increase observed in 1918, for which the death rate increased to 1,810 per 100,000. But, overall, the declining death rates resulted in an increase in average life expectancy. In 1900, the average life expectancy at birth was 47.3 years; by the year 2000, life expectancy had increased to 77.0 years (74.3 for males; 79.7 for females).

The declining death rate was the result of a decrease in the affect of infectious disease, particularly influenza, pneumonia, and tuberculosis. The declining death rate due to infectious disease continued during the second half of the 20th century until about 1980 to the mid-1990s during which time the affect of HIV/AIDS is noted.

The Changing Focus in Cause of Death

The remarkable decline in infectious disease deaths during the 20th century was due to the application of scientific advances achieved during the late 19th century, including widespread public works programs and cleaning up streets and public areas to control the spread of disease. Implementation of quarantines for contagious disease, the use of vaccinations and antitoxins, enactment of standard procedures for handling food products, elimination of public access of dangerous medications through the establishment of the Pure Food and Drug Act of 1906, and stricter licensing of medical practitioners enhanced public awareness and government governance. The creation of germ theory by Louis Pasteur in the 1860s and the introduction of safe surgery at Johns Hopkins University led to further improvements in public health and a lessening of the effect of infectious disease.

With the decline of infectious diseases a concomitant change in the major causes of U.S. death also occurred, shifting in the early portion of the 20th century to chronic disease. Deaths due to infectious diseases declined, while heart disease became the leading cause of death starting in 1910, and in 1930 cancer emerged as the second leading cause of death. The death rates due to heart disease

were highest in the 1960s and 1970s; however, since that time the number of heart disease deaths has been declining.

During the second half of the 20th century medical research focused on chronic conditions, which led to increased awareness of disease causes and symptoms. A result was improvement in medical tests to detect early onset of numerous diseases, including heart disease and various cancers, as well as tests for genetic predisposition for certain degenerative and chronic conditions. Medications were introduced to treat or control the progress of chronic diseases such as high cholesterol and hypertension. Research also emphasized the influence of lifestyle factors, such as smoking, high-fat diets, and exercise on greater risks of early death.

The development of germ theory and the practice of preventive medicine and better sanitation also had an effect on reducing noncombat-related deaths due to infectious and contagious diseases for American soldiers at war during the 20th century. However, during World War I, the rate of noncombat deaths was high due to the 1918 worldwide influenza epidemic at the end of the war. The discovery of penicillin in 1943, and other antibiotics, also reduced nonbattle casualties for soldiers in World War II and later wars.

Differences in Mortality Rates

In the first half of the 20th century, mortality rates dropped for all ages—but most notably for infants, children, and young adults—as a result of the reduction of infectious and contagious diseases. Since the late 1960s death rates have declined rapidly for persons age 65 years and older due to medical advances in diseases of old age.

Females have longer life expectancy, and thus, lower death rates than males, although the gap has fluctuated over the past century. At the beginning of the century the gap was small (approximately 2 years) due to females' vulnerability to infectious disease and high rates of maternal mortality (i.e., deaths during pregnancy and childbirth). Female deaths due to infectious disease declined in the first two decades, although maternal mortality deaths remained high until the mid-1930s, primarily due to no or inappropriate care for birth complications. Maternal deaths declined from 1936 (582 deaths per 100,000 live births) to 1956 (40 deaths per 100,000 live births) due to the growth of obstetric care, the use of antibiotics to fight infection, more appropriate methods to deal with delivery complications, and the use of trained midwives for home births. The gap in male–female life expectancy widened until the mid-1970s because of increased male disadvantage in deaths from heart disease and cancer and declining rates of maternal deaths for females. The narrowing of the gap at the end of the century occurred with greater male improvements in deaths due to heart disease, cancer, suicide, and homicide.

There were great differences in death rates by race at the beginning of the 20th century, with average life expectancy at 47.6 years for whites and 33.0 years for nonwhites. By 1970, data were routinely collected for mortality statistics for African Americans. At this time the black–white gap in life expectancy yielded a 7.6-year advantage for whites. By the end of the century the gap had narrowed to 5.7 years with black average life expectancy at 71.9 years and 77.6 years for whites. The improvement in African American life expectancy has occurred due to declines in death rates for homicide, cancer, stroke, and HIV disease.

Black–white differences in infant death rates, which is the death of infants before their first birthday, also accounts for the life expectancy gap by race. Early records indicate that in 1916 the black infant death rate was 184 per 1,000 live births, whereas the rate for whites was 99. By the year 2000 the gap between blacks (14.0 deaths) and whites (5.7 deaths) had gotten smaller; however, the rate of black infant deaths was 2.5 times larger that that for whites. Much of the black–white infant death rate gap has been attributed to socioeconomic factors, such as mother's education and income; mother's health; access and use of prenatal health care; and birth outcomes, such as low birthweight.

The 21st Century and Future Causes of Death

The first 5 years of the 21st century have yielded a continued decline in death rates in the United States, particularly for persons over the age of 65 years. Total life expectancy in 2005 was 77.8 years. The male–female gap has decreased to

5.2 years (75.2 for males; 80.4 for females) and the black–white gap has decreased to 5.1 years (73.2 for blacks; 78.3 for whites). With increases in life expectancy and age of death, there have been some changes in the causes of death in that diseases that are more prevalent in the oldest ages, such as Alzheimer's disease and other dementias, are becoming more prevalent as causes of death. Another trend that will affect future causes of death is the growing prevalence of obesity across all age groups, particularly in the United States. Obesity has been linked with greater rates of diabetes, stroke, heart disease, and certain types of cancer, so increases in death rates most likely will occur in the future.

The United States has experienced one of the largest waves of immigration in its history, and there have been concerns about immigrant health. The majority of the recent immigrants have come from poor countries in Latin America and Asia, and many are in poor working conditions such as manual labor and are experiencing exposure to harmful agents such as pesticides and other chemicals. Poor immigrants are less likely to have access to adequate health care and are less likely to be immunized. Such factors may lead to increasing death rates at younger ages.

Although deaths due to infectious and contagious diseases declined precipitously during the beginning of the 20th century, by the end of the century there emerged new, more lethal infectious diseases, such as Legionnaires' disease, HIV/AIDS, Ebola virus, and severe acute respiratory virus (SARS) in addition to more drug-resistant strains of diseases such as malaria and tuberculosis. Factors that have led to the resurgence or spread of infectious diseases include greater travel between the Western world and remote or third world countries where there has been increased urbanization and overcrowding. In addition, the increased use of antimicrobials in food additives for animal production has led to resistant strains of *E. coli*, *Salmonella*, and other contaminants in food, air, and water, which have caused deaths and other health concerns.

Finally, climate and environmental changes are going to have an effect on all populations. The Western world is not immune to such changes, as evidenced by the effects of hurricanes, heat waves, and other natural disasters. Climate and environmental changes are going to have effects on food and water supplies, as well as other resources, which will ultimately affect death rates.

Vicki L. Lamb

See also Demographic Transition Model; Epidemics and Plagues; Gender and Death; Infant Mortality; Life Expectancy; Mortality Rates, U.S.; Race and Death

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Cemeteries

It was Elias Leavenworth who, in 1859, identified the cemetery as "the last great necessity" for his community, and for most of history it has been seen as such. However, globalization and the growth of new immigrant and ethnic communities from cultures and religions with divergent views about death and the dead are similarly manifested in divergent burial practices.

The word *cemetery* is derived from the Greek word for sleeping chamber, as the ancient Greeks believed that the dead were temporarily resting, awaiting the Day of Judgment when chambers would be emptied. Cemeteries are differentiated from other types of burial sites, such as graveyards

or churchyards, pauper's fields, mass graves, pantheons, or burial grounds. Modern-day cemeteries and memorial gardens are large parks for the interment of the dead and, unlike graveyards, are not attached to churches. They often represent a place for ritualized burial needs for a distinct community or culture of peoples. Their internal layout is ordered so that entire families can claim and control grave spaces. They tend to be secular, municipal entities serving a geographic region, community, ethnic group, or religious group. In the United States, due primarily to health concerns in the 17th century, cemeteries were located on the outskirts of towns. Today, space limitations force cemeteries outside of heavily populated urban areas.

Historically, cemeteries were central to community life and to the continuity of families, functioning to provide a physical place where people could visit, remember, and pay their respects to the dead. The significance of the cemetery in today's mobile and diverse societies is more complex, and it is not unusual for families to bury their dead and never return to that burial place. Alternatives to burial, primarily cremation, changing attitudes about death, and changes in the cultural symbolism of cemeteries all suggest evolving cosmological belief systems such as John Stephenson identified in his ages of sacred, secular, and avoided death.

American Cemeteries and Christian Traditions

In the United States the evolution of cemetery practices and the shifting meaning of death can be traced to the early colonial period, when cemeteries took the form of church or town graveyards and iconography encompassed an age of sacred death. Prior to the mid-1600s there is no indication that the New England Puritans marked the graves of their deceased, but by the 1660s the practice of grave marking was widespread. James Deetz documents that stonecutters used three basic designs: death's heads, winged cherubs, and a willow tree overhanging a pedestaled urn. Death's heads were most common from the 1680s to the mid-1700s. In the same genre were carvings that emphasized the flight of time: the hour glass, a scythe in the hand of death or father time, skeletons, crossbones, and death darts. Death heads tended to become less severe during the early 18th century, metamorphosing into a pleasant cherub or angelic image. Some carvings began to use background designs of foliage, grapes, or hearts that softened the presentation of death. Verses of consolation and lines of poetry conveying a message of hope also began to appear. Increasingly, death was portrayed as benign sleep. The new gravestone art symbolized optimism, depersonalization of death, and a new interest and appreciation for nature. The optimism reflected changing religious beliefs from the Puritan doctrine of predestination to the notion that in Jesus Christ, individuals could find salvation that would ensure life after death. The willow tree and urn motif also marked the end of town graveyards of the colonial period and the rise of the modern cemetery.

Between the 1830s and the 1850s, reflecting a transition from sacred to secular death, American burial space was transformed from the urban decay reflected in city church graveyards to a natural garden park providing a resting place for the dead and a scenic sanctuary for the living. The rural or garden cemetery movement epitomized the view of death as a natural part of the life cycle. A growing, affluent class of new urban citizens attached increasing romantic importance to nature, embraced more liberal religious beliefs, and changed the prevailing attitudes about death. The new cemeteries were referred to as "rural," although in reality, they were located on the perimeters of large cities, designed to create a natural haven for repose as city dwellers became overwhelmed by the urban landscape.

Garden cemeteries, reflecting an age of avoided death, evolved further between the 1850s and 1950s into what we know today as lawn-park or memorial park cemeteries, functioning to separate the living from the dead. Encapsulated in the organization of memorial parks is a highly routinized and controlled perpetual-care private business with its concomitant specialized management of death by death professionals and attendants. Unlike the rural garden cemeteries, the memorial park no longer makes nature a central feature. Only evergreens are used, because the browning of leaves is a reminder of death. Individual ground markers of bronze or granite have replaced the older formation characterized by a large family marker and rows of smaller individual headstones. Reminders of death in epitaphs and symbolism are

minimized. Strict management principles regulate the architecture and upkeep of the grounds. Full-service and professional packages, including real estate, life insurance, burial insurance, pre-need planning, and promises of perpetual maintenance (all for a price) are incorporated. If efficient business strategies formed the economic base of memorial parks, then promises of Christian immortality, resurrection, and eternal life formed its cosmological package. With the emergence of lawn-park and memorial gardens, shifting attitudes about the meaning of death reflect what James Farrell describes as "the dying of death." Fast convenient services in a commodified and commercialized environment are part of a larger trend in separating Americans from the realities of death. Similarly, it was during this age of avoided death that cremation became more prevalent in North America.

Variations in Cemetery Traditions

Jewish Cemeteries and Burial Traditions

Establishing a community cemetery is one of the first priorities of a Jewish community, as cemeteries encapsulate a set of customs and traditions connected to the burial of the dead. According to Maurice Lamm, a cemetery is considered Jewish if the purchase contract identifies it as exclusively for Jews, the cemetery corporation forfeits any rights to removal of burial remains, and facilities for Jews and non-Jews have separate entrance gates. Jewish cemeteries are located all over the world in various states of preservation and disrepair. The Old Jewish Cemetery of Josefov in Prague is the oldest Jewish cemetery in Europe, having survived Hitler's army only because he intended it to become part of the Prague Jewish Museum of extinct people. Over 100,000 Jews are buried in this small cemetery with approximately 12,000 tombstones and graves sometimes layered 12 deep. The Jewish ritual of *Nichm Avelim* is intended to comfort the bereaved and to beckon mourners to return to society. During the *shiva*, the first seven days of a 30-day mourning period (*Sheloshim*), mourners assemble after the burial at the borders of the cemetery, forming row after row of 10 or more persons. This graveside ritual is repeated when the mourners return to the home of the deceased. It is also customary in Jewish cemeteries to place a *matzeivah* or tombstone at the head of the grave to honor the deceased. Rather than bringing flowers to the grave, it is customary for visitors to bring pebbles left on the tombstone as tokens that individuals have been there to visit and to remember. The origin of this tradition is unknown but according to some people, it dates back to biblical times when Jews, forced into a nomadic life, died wandering in the desert, their graves left behind with no one to tend them but protected under piles of stones. Another explanation links the tradition to the practice of shepherds who, in an effort to keep track of their flock, would place a pebble in their sling for every sheep. In placing a stone on the grave, a visitor offers the prayer that God will keep the soul of the departed in his sling.

Muslim Cemeteries and Burial Traditions

In Muslim tradition, earth burial for the deceased is prescribed and the dead are typically buried within 24 hours. In non-Muslim countries it is often difficult to find all-Muslim cemeteries or those that accept Muslims and provide a separate section for their burial. Where Muslim cemeteries or sections of cemeteries exist, they are often characterized by open areas of land with few markers and are not readily identified as cemeteries. Muslims typically do not use distinguishable grave markers and tombstones as is common in Christian cemeteries. Muslim traditions for burial of the deceased are simple but precise. As with Christians, Muslims believe that the soul of the deceased leaves the body, awaiting a final Day of Judgment and Resurrection (*Youm al Ghiyammah*), when all will stand before God, their good and evil deeds weighed to determine entry into paradise (*junna*) or hell (*jahim*). Muslims prefer a speedy burial and typically do not use embalming or coffins, unless required to by local laws. When coffins are required, a simple wooden box is used. Immediately upon death a two-stage cleansing ritual is performed with quiet reverence by same-sex family members. The body is arranged in a sleeping position, then wrapped in cloth, three layers for men and five layers for women. There is one exception to this preparation. In the case of martyrs (*shuhada'*) the body is not washed and is buried in the same attire worn upon death.

Muslim burial is typically a male activity. Women are not prohibited from attending the

burial, but in most Muslim societies women are not allowed to carry the body or accompany it to the grave site. At the burial site a prayer is offered for the forgiveness of the deceased soul, unless it is a child (who is expected to go directly to paradise). The body is lowered into a 4- to 6-foot deep grave; inside the grave is a narrower cavity referred to as the *lahd*. The body is placed in the lahd resting on its right side facing Mecca (the Muslim Holy City). The lahd is then sealed (the body is walled in) with mud bricks made from the soil used to dig the grave. Finally, the grave is filled and another prayer is offered. If a grave is marked, it is by a modest marker placed at the head of the deceased; its purpose is practical rather than symbolic.

Spanish-Mexican Cemeteries

Traditional community cemeteries still exist in some parts of the United States, most prominently in small towns, rural areas, and among some ethnic groups. Mexican folk cemeteries are a good example, representing the ancestral influence of Indians and Spanish Catholicism. *Camposantos* (Field of Saints) in the southwestern United States are characterized by crosses of wood or wrought iron; *cerquitas,* wooden or medal enclosures surrounding the individual or family graves; and *relicaritos* or *nichos,* to receive personal items, holy objects, or photographs. Family plots are not as commonplace in camposantos as in other cemeteries, and the spatial organization typically emphasizes the individual rather than the family. This may be a function of economic necessity as families purchase individual plots as needed but cannot afford the cost of larger, more expensive family plots. In Mexican cemeteries, or Mexican subdivisions of cemeteries today, the crosses are often painted or wrapped in bright colors. Vegetation is rarely planted and grass is often "scraped" from graves. Family and friends of the deceased freely express their emotions by creating personal grave markers, artifacts cherished by the deceased or believed to facilitate communication. Common grave decorations include handwritten notes, greeting cards, animated balloons, religious objects, coronas (wreaths), toys, canned drinks, and personal possessions. This means of remembering a loved one allows families to maintain a relationship with the departed and suggests an acceptance of death as an inevitable part of life. Many camposantos in the United States today are not being preserved. Yet for some traditional Mexican and Mexican American communities, All Souls' Day (November 2) is still a day for cemetery cleanings and a time when families, the community, and the church come together.

African American Cemeteries

Although Africans have been in the United States since the early 1600s, there is little evidence of their earliest burial sites, which have been ignored, built over, paved over, or simply lost to time for lack of permanent markers. Dating back to the 1690s, the oldest known burial ground for Africans in the United States was located in lower Manhattan near the poorhouse, the workhouse, and the debtor's prison. Thousands of Africans, and some African Americans, were buried there, in a site almost forgotten until 1991 when excavation began to make way for a federal office building. Excavation was stopped and, after much public debate, the six-acre burial ground received National Historic Landmark status. Segregated burial facilities appear to have been the rule both in areas that supported slavery (and later, legal segregation) and in those that did not. Few records remain of the customs surrounding slave burials. Whether there were open or secret ceremonies depended on the slave owner. If there were no designated cemeteries for slaves, gravesites were in secluded or secret spots, long since lost to time. Graveside services included a sermon or eulogy, followed by family and friends throwing dirt into the open grave. Sometimes the grave was covered with broken earthenware, commemorating the broken body lying beneath the soil. Perhaps a West African influence, seashells were also a common form of grave covering well into the 20th century.

In the 21st century, many African Americans bury their dead in the same cemeteries as whites, and there are no distinctions in the markers or the messages. Some segregated or largely African American cemeteries, however, remain to provide a history of how a segregated people buried and remembered their dead. These cemeteries provide members of a given community with both geographic and historical roots, manifested in annual "cemetery workings" that are a part of many community homecomings and family reunions, especially in the South.

Native American Burial Practices

Native American burial practices are diverse, reflecting the many different tribal customs and beliefs from which they emanate. Some tribes are known to have placed their dead on above-ground scaffolds or in trees from which bones were gathered and deposited in earth pits. Some tribes practiced cremation; other buried their dead in the floors of their houses, and some built spirit houses. Despite tribal variations, most practice burying valuables with the deceased, believing that if these are withheld, the spirit will return to reclaim them or the loved one will not be able to make a smooth transition into the spirit world. These artifacts have made Native American burial sites of interest to outsiders with varying motives. Memorial markers were rare in early Native American burial grounds, but today differences separating Native American burials and cemeteries are diminishing. Their gravestones honor the Native American and Christian or secular cultures. Differences that persist are among tribes that remain relatively isolated, their graves still draped with traditional tribal blankets and prayer ribbons attached to nearby trees. Some tribes still wrap the body in a blanket or a special skin robe secured with rawhide ropes before burial. Prayer ribbons or prayer sticks of bright colors are placed at the site of the burial to carry the deceased to the spirit world.

In recent years, it is the reburial of Indian remains excavated or exhumed by archaeologists, anthropologists, and government agents that has claimed attention. The reburial movement began in the 1970s, generated legislation in several states, and, at the federal level, culminated in the Native American Graves Protection and Repatriation Act of 1990. The legislation acknowledges that Indian remains are human remains and not archaeological resources; it prohibits further excavation of burial sites and requires that such remains be returned to the home tribes for burial.

Other Cemetery Practices and Postmodern Death

Although largely a relic of the past, fraternal-order cemeteries, or sections of cemeteries, are yet another way that some Americans and Europeans marked the end of life on earth. Most of the cemetery variations noted here are those associated with affiliations or identities of the deceased, some achieved and some ascribed. There are, of course, other groups worthy of study for how they express their unique culture and their philosophy of death (or life) in the way they bury their dead. By contrast, there are those buried in anonymity for lack of any affiliation or identity (e.g., those buried in potter's fields). Variables other than group identity, such as nature or geography, can also dictate how some bury their dead. For example, San Francisco's limited land base is responsible for Colma, California, becoming the world's only incorporated city where the dead outnumber the living. Colma, a suburb of San Francisco, was destined to become a necropolis when San Francisco prohibited burials within the city in 1902. Nature and culture apparently combine to account for yet another cemetery tradition—that of above-ground burials such as found in New Orleans, Louisiana, or Galveston, Texas, where floods washed out graves before the coasts were contained with various forms of levees and dikes. What began as necessity, however, has continued as the burial style of preference for many New Orleanians.

In the postmodern world the demands of death for family and community are diminished as funeral parlors, perpetual-care cemeteries, and crematoriums assume the tasks of disposal. Although the trend of separating the dead from the everyday world of the living originated in North America, the separation between the living and the dead has never been complete. If, as Stephenson contends, it is the historical character of the "event of death" that stimulates ceremonial response, in the form of memorialized ritual and material artifacts, then a strong case can be made that in the postmodern era, both traditional and new forms of memorialization exist side by side. Perhaps the most interesting example of contemporary cemetery practices is evident in temporary, drive-by, and makeshift memorials representing substitute cemeteries. In the wake of the age of avoided death, new forms of community expression suggest a collective social identity and, at times, a global identity, as in the passing of a beloved public figure. The events of death precipitating these new forms of expression are perhaps best described as a new age of "untamed death." Premature deaths, violent deaths, random killings, and the threat of terrorist activities have brought the realities of unexpected and early death into public consciousness. This qualitative

transformation in the meaning and significance of death has led many to embrace a renewed interest in the memorial ritual and relic. In the postmodern era of untamed death, traditional values have been renewed. Yet, while cemeteries remain the preferred last resting place for a majority of the population, they are no longer "the last great necessity." Death, while still sacred to some, secular to others, avoided by most, and untamed for all, today takes the final remains to diverse ends and forms.

Vicky M. MacLean and Joyce E. Williams

See also Cemeteries, Unmarked Graves and Potter's Field; Cemeteries, Virtual; Memorials; Memorials, Roadside; Spontaneous Shrines; Stephenson's Historical Ages of Death in the United States; Tombs and Mausoleums; Tombstones

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Cemeteries, Ancient (Necropolises)

Originating from the Greek for "sleeping place," the term *cemetery* refers to a place designated exclusively for the burial of the dead. A large cemetery associated with an ancient city is termed a *necropolis* (plural *necropolises*, *necropoles*, or *necropoleis*), derived from the Greek *nekropolis*, meaning "city of the dead." Necropolises took a variety of forms, linked to the cultural context in which they developed, but all were designed to provide a purpose-built location for the disposal of the dead. The necropolis was an important element in the definition of the ancient city and, although many were located outside or away from the city of the living, they maintained an important role in contemporary society. Cemeteries associated with major ancient civilizations, including those of Egypt, Greece, and Rome, have been extensively excavated and their architecture, decoration, and material culture provide insights into the social and religious lives of ancient people.

Ancient Egypt

The cemeteries associated with successive Egyptian royal capitals remain among the most impressive of the ancient world. Belief in life after death was fundamental to ancient Egyptian religion and as a consequence elaborate tombs, furnished with worldly comforts, were built to protect the body and ensure a happy afterlife. The decoration of many tombs illustrates aspects of daily life or activities the dead hoped to enjoy in the afterlife. Food preparation, also commonly depicted, was believed to provide sustenance for the inhabitant of the tomb. Egyptian cemeteries were often sited on the edge of the western desert, a location linked not only to religious beliefs about the afterlife and the sun, but also to the need to preserve precious agricultural land along the Nile.

The earliest cemeteries were located in the north of Egypt, including the famous necropolis at Saqqara, 30 kilometers south of modern Cairo, which served the city of Memphis. It was here that the earliest known step pyramid was built for Djoser (ca. 2667–2648 B.C.E.), along with 16 later pyramids. The step pyramid developed as a more

elaborate form of the traditional flat-roofed rectangular mastaba tomb, with successively smaller mastaba-like structures being placed on top of one another. Such structures distinguished themselves and their occupants from the traditional mastaba, which continued to be built alongside the pyramids. During the Fourth Dynasty (2575–2467 B.C.E.) the stepped pyramid evolved into the more familiar pyramid, such as those at Giza. The pyramid of the Fifth-Dynasty Pharaoh Unas (2375–2345 B.C.E.) at Saqqara contains the earliest known example of the Pyramid Texts, the precursor of the New Kingdom *The Book of the Dead*, giving instructions for the afterlife.

One of the most famous ancient Egyptian cemeteries was located at Thebes, in southern Egypt. Dating predominantly from the New Kingdom period (ca. 1560–1085 B.C.E.), when Thebes lay at the center of a vast Egyptian empire, the necropolis was created on the opposite bank of the Nile to the city and housed the tombs of nobles, courtiers, and other officials. Prior to the New Kingdom, Egyptian kings favored elaborate monumental pyramids, which were designed to impress, but repeated tomb robbing led increasingly to the use of a secluded valley behind the necropolis, known today as the Valley of the Kings. This cemetery was composed of tombs cut deep into the rock with a single access passageway and no external structure. Once burial was complete, the entrance to the tomb was concealed.

Cemeteries played an essential role in Egyptian religious belief and culture. The fact that tombs were normally built of more durable material than the mud-brick buildings of the city demonstrates vividly the belief that the tomb was to be the eternal home of the deceased's spirit and should be virtually indestructible.

Ancient Greece

The ancient Greek necropolis was traditionally located outside the walls of the city and, from the 6th century B.C.E., intramural burial at Athens was officially prohibited. This was linked not only to a desire to avoid disease and religious pollution but also to the need to preserve valuable urban space, and many Greek cemeteries were consequently constructed along roads leading out of cities. The necropolis was particularly important for Greek urban society because citizenship was signaled through burial within a recognized cemetery. The emergence of differing forms of commemorative monument and grave marker reflect the role played by the necropolis in the social and political life of the city.

The Kerameikos, or Potter's Quarter, is the best-known cemetery of ancient Greece. Located to the northwest of the city of Athens, outside the Sacred and Dipylon Gates, this area contained potters' workshops and was the main production center for Attic vases, but from around 1200 B.C.E. it was also the site of an organized cemetery. During the Geometric (ca. 1000–700 B.C.E.) and Archaic periods (ca. 700–480 B.C.E.) the Kerameikos housed increasing numbers of complex grave monuments. Funerary vases (amphorae) known as *lekythoi* were used as grave markers during the later Geometric period, some achieving heights of 5 feet. The use of lekythoi continued during the 7th century B.C.E., but monumental earth mounds also began to be constructed over individual and family burials. More elaborate commemorative monuments, in the form of sculpted or painted stone stelae and inscribed epitaphs that displayed information about the deceased, became the prevailing form of grave marker during the 6th to 4th centuries B.C.E. On occasion freestanding statues (kouroi) were also employed as markers. Stone vases, which mimicked the lekythoi of earlier periods, continued the traditional custom of marking graves with vases. In 478 B.C.E. the Kerameikos was divided by a new city wall, into which many existing funerary structures were incorporated. State burials of heroes continued on both sides of the wall, including those of Pericles and Cleisthenes. The construction of mausoleums was prohibited in 317 B.C.E. by a decree designed to curb extravagance in funerary activities. Following this decree, graves in the cemetery were marked by small columns or inscribed square blocks of marble.

Ancient Greek cemeteries were a place for the celebration of funerary rites and the remembrance of the deceased, but they also played a vital role in social and political negotiations in the city. Commemorative monuments could be used to distinguish members of the community from one another, in terms of wealth, status, or identity.

Etruscan Italy

The cemeteries of Roman Italy owe much to their Etruscan antecedents, found at Cerveteri (ancient Caere), Tarquinia, and Volterra. The Etruscan necropolis was composed largely of chamber-tombs, partly cut into the rock and partly built of masonry, many of which were covered with large earthen mounds. Other, rectangular tombs stood alone or in groups, normally aligned with internal cemetery streets. The Banditaccia necropolis at Cerveteri (9th to 2nd centuries B.C.E.) provides an example of the organization and planning of Etruscan cemeteries, with tombs aligned on a regular street grid. The interior of an Etruscan tomb was sculpted in order to reflect the appearance of a house, and the stucco of the Tomb of the Reliefs at Cerveteri depicts the items of daily life that the dead required in the afterlife.

Ancient Rome

The ancient laws of the Twelve Tables legally prohibited burial within a Roman city or town so cities of the dead developed on the outskirts of urban areas. Like those of ancient Greece, Roman cemeteries were normally strung out along roads leading from the city; examples can be found on the Via Appia Antica at Rome and the Via dei Sepolcri at Pompeii, where tombs and monuments cluster along the edges of the road. Many expansive cemeteries retained the pattern of the Etruscan necropolis, with an internal network of streets. This can be seen at Ostia, and particularly in cemeteries of the 1st and 2nd centuries C.E., composed of groups of brick-built house-tombs, including those of the Vatican necropolis and Isola Sacra (near Ostia). Unlike their Etruscan counterparts, there was little control over the growth and organization of Roman cemeteries. All members of the community, regardless of rank, used the necropolis, and the spaces between monumental tombs were often occupied by burials of the lower classes. Competition for prime roadside locations exerted a strong influence over the development of the Roman necropolis, reflecting the significance of the city of the dead in negotiations for status and identity among the inhabitants of the cities of the living.

At Rome during the late 1st century B.C.E. the necropolis environment was central to elite competition, as individuals sought to create new and unique forms of monuments in order to advertise their wealth and social status. This led to the creation of tombs such as that of Gaius Cestius outside the Porta Ostiensis, which took the form of a marble-clad pyramid. These elaborate tombs developed in a political climate of competition during the late Republic, but the construction of a magnificent circular mausoleum for the new Emperor Augustus effectively put an end to elite competition within the funerary sphere. However, the Roman necropolis continued to be a place for expression as other members of the urban community grasped the opportunities it offered for display. This was particularly important for the freedman (ex-slave) population of the city who were particularly anxious to find an expressive outlet for their newfound citizenship, legitimacy, and economic or personal success. The cemetery increasingly became an arena for the ordinary people of the Roman world.

The Roman cemetery was not only a place for the display of status; it was also the place in which the dead were remembered through ongoing religious rituals. Roman beliefs concerning the afterlife were vague, and philosophical arguments for the absence of an afterlife competed with traditional beliefs that the spirit of the soul inhabited the area of the grave and required sustenance. Epitaphs plead with the viewer to remember the dead and reflect a widespread fear of oblivion and desire for remembrance. The cemetery was visited regularly, on the anniversary of the death and birthday of the deceased, and during annual festivals of the dead, such as the Parentalia (February) and the Lemuria (May). On these occasions the surviving relatives consumed banquets and made offerings to their deceased forebears. Tombs were regularly furnished with facilities to assist with these activities, including libation tubes, dining couches, wells, and ovens. The Roman necropolis formed a focus of activity throughout the year despite its relegation to the suburbs of the urban area, and ancient sources mention prostitutes, robbers, and witches frequenting the tombs after nightfall.

Overcrowding and pressures on burial space led to the excavation of the first Roman catacombs during the 2nd century C.E. These networks of underground galleries were furnished with niches (loculi) designed to accommodate inhumations.

The catacombs housed the burials of pagans, Jews, and Christians alike, and represented an entirely new form of public subterranean necropolis. Only later, during the Christian period, did this distinction become blurred, as the graves of martyrs became the focal point for religious worship. Eventually, the division between the city of the living and that of the dead disappeared completely, as intramural Christian basilicas across the empire became focal points for burial. The true necropolis, a space designated specifically for the dead, was replaced by the grave- or churchyard, which came to dominate medieval burial patterns.

Emma-Jayne Graham

See also Ancient Egyptian Beliefs and Traditions; Cemeteries and Columbaria, Military and Battlefield; Egyptian Perceptions of Death in Antiquity; Tombs and Mausoleums

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Cemeteries, Pet

It has often been observed that most of what we know of early civilizations is based on their funerary artifacts. One wonders what inferences will be made by archaeologists in the future when discovering hundreds of pet cemeteries from early 21st-century America, some with owners interred next to their animals. Indeed, future archaeologists may collaborate with historians to explain how the emergence of pet cemeteries in the late 19th century and their proliferation in the late 20th century are the result of sociocultural trends. Interestingly, researchers will not find any mortuary attention being given to dead animals a century earlier because these geographies reflect new moralities toward nature and the animal kingdom as well as profound alterations in familial and friendship bonds.

As is the case for the human elite, pet cemeteries and memorializations originally were limited to the animal elite and to the elites' animals. Near the track of the Kentucky Derby at the Old Friends Thoroughbred Memorial Cemetery is the final resting site for the equine stars of the race track. Among those interred at the Kentucky Horse Park is Man O' War, whose 1947 funeral was attended by 2,000 mourners. Similar species exclusivity can be found in Tuscumbia, Alabama, where since 1937 can be found the Coon Dog Cemetery. Reserved for working canines, at the Broward Pet Cemetery in Plantation, Florida, is the Service Dog Resting Place, which houses the remains of seeing-eye, drug detection, and search-and-rescue dogs.

As there exist national cemeteries for military veterans, so too for their pets. At San Francisco's Presidio is a cemetery for pets of army families stationed there. Some claim it originally was a burial ground for 19th-century cavalry horses or World War II guard dogs. Nevertheless, for the last half of the 20th century until closing to new interments, it remains the final resting place of not only dogs and cats but parakeets, hamsters, lizards, and rabbits.

The animal elite have also been buried alone in small consecrated sites. Ham, the first chimp in outer space, is buried in the front lawn of the International Space Hall of Fame in Alamogordo, New Mexico. In the same state Smoky the Bear was interred beneath a memorial plaque in the Capitan National Forest. Mitzi, of television "Flipper" fame, is buried beneath a dolphin statue in the courtyard of Santini's Porpoise School.

North of New York City in the affluent areas of White Plains and Scarsdale is the Hartsdale Pet Cemetery & Crematory, which advertises itself as the nation's "first and most prestigious pet burial grounds." Established during the height of the

Gilded Age and Victorian sentimentality in 1896, this final resting place of over 70,000 animals promises to "help keep the memory of your pet alive." Among the creatures there buried is Chips, who served in a number of General Patton's campaigns and alone took control of an enemy pillbox by grabbing the throat of the gunner and terrifying five other occupants into surrendering. He is joined by less accomplished creatures from higher status households, whose memorializations could be perceived as examples of conspicuous consumption. Thorstein Veblen, in developing the ways in which the economic elite demonstrate their wealth, included the notion of conspicuous waste. Veblen's work was published at the turn of the 20th century, when new waves of immigrants were struggling to feed their families and having to bury their dead in pauper fields, and the rich were interring their dead pets beneath exquisite monuments.

But the nation's upper crust had no monopoly over the love for pets or the grief over their deaths. According to the International Association of Pet Cemeteries and Crematories (est. 1971), Hartsdale is currently one of 600 active pet necropolises in the United States—50% more than in the mid-1980s—most being species heterogeneous and less exclusive in terms of animal accomplishments and owners' social status.

Emulation of the affluent fails to account for the proliferation of pet cemeteries. Also involved is a changing relationship between humans and their animals. Perhaps these people considered their animals sacred, as did the Egyptians 3,000 years earlier, who mummified their cats like their pharaohs and buried them within their own cemeteries—or as the ancient Persians did in what is now Ashkelon, Israel, where archaeologists located a large cemetery filled with but one breed of a whippet-like dog, each with its own grave and all apparently having died of natural causes.

Funerary attention is given to select social bonds and the stories above indicate a profound change in our relationship with animals. Two generations ago people did not employ veterinarians for non-working creatures. Cats and dogs were more disposable. Times were different when individuals were economically dependent on their farm animals—people often knew how to assist with births and remove porcupine quills, for example. Animals had roles. They worked and they did not come into the living quarters, because animals were, after all, the sources of most human epidemics. Today, however, creatures are pets and serve as companions—and are even considered as family members by roughly half of dog and cat owners, according to a 2006 survey by the American Veterinary Medical Association.

The mortuary attention given to pets is also testament to Americans' failures to connect with others. One sociological study found that Americans had fewer close friends and confidants in 2004 than they did 2 decades earlier, with the average individual having but two people in whom they felt they could confide important matters. One in four had no close confidants. The social void is countered with pets, whose fidelity and companionship address the loneliness. Dogs have long epitomized such unconditional loyalty, symbolized by the Victorian saga of Greyfriars Bobby of Edinburgh, Scotland. So devoted was the Skye terrier to his master, John Gray, that when the latter died the dog kept vigil over his grave for 14 years, leaving only for a midday meal, despite attempts of authorities to banish him from the churchyard. The survival of love after death resonated with the sentimentalities and mourning customs of the era. A monument was erected to the canine with the inscription "Greyfriars Bobby—died 14th January 1872—aged 16 years—Let his loyalty and devotion be a lesson to us all."

The 2005–2006 National Pet Owners Survey by the American Pet Products Manufacturers Association found pet ownership was at its highest level, with 63% of all U.S. households owning a pet. The intensity of the bond was detected in a 2007 Department of Homeland Security study of the inadequacies of mass evacuation planning in the wake of Hurricane Katrina. Among the many failures of taking into account human nature, the study found many people refusing to budge if they have to leave their pets behind. An interview with a major San Antonio (Texas) funeral home revealed that roughly one quarter of its obituaries now include pets as survivors.

There's a new contract between pet and owner: The former is entitled to human quality-of-life standards, and it is the latter's responsibility to provide it. This relationship has been increasingly capitalized on by the service economy; in 2007, Americans spent over $40 billion on their pets—double

the expenditures of a decade earlier. Many employers now offer pet health insurance. Pet day care centers, whose fees rival those for child care, have sprouted across the country. According to the American Pet Products Manufacturers Association, 42% of dogs sleep on their owners' beds. With such financial investments and emotional connection, pet deaths amplify the sense of loss. Roughly one quarter of pet owners, according to the American Pet Products Manufacturers Association's 2007–2008 National Pet Owners Survey, intend to make some purchase to memorialize their pet. In 2008, Kates-Boylston Publications began its *Pet Loss Insider* monthly newsletter.

Pet owners' grief has traditionally been disenfranchised, producing a vacuum now addressed by a growing mortuary industry paid to recognize their grief and to address it with funerary paraphernalia developed in the funeral industry for humans. Initially pets were the recipients of adult hand-me-downs, such as the use of infant coffins. Now manufacturers make an array of such conveyances available and at considerable cost.

At a deeper symbolic level, underlying the proliferation of pet cemeteries is the blurring of boundaries between the cultural and natural orders. Traditionally these realms were perceived to be antithetical, the former set up in opposition to the threatening latter. Instead of being seen as a threat to human well-being, the natural order is presently understood as inseparable from the cultural, its creatures viewed with compassion and respect.

In 1993 and 1994, researchers of the National Opinion Research Center posed to random samples of American adults the statement "Animals should have the same moral rights that human beings do." Nearly 3 in 10 Americans either agreed or strongly agreed. As the moral rights of animals gain acceptance so too are their legal rights: 90 of the 195 accredited law schools in the United States offer courses on animal law. Thirty states have legally enforceable trust laws for pets.

These trends set the stage for the 2007 morality play involving a professional football player who, after considerable publicity, was imprisoned for promoting dog fighting. We view ourselves as a people having evolved from being spectators enthralled by bear-baiting and cock fights to stewards of animal welfare (an idea institutionalized in 1954 with the founding of the Humane Society of the United States) and agents of animal rights (state charters of the American Society for the Prevention of Cruelty to Animals and animal protection legislation appeared in the decades immediately following the Civil War). Given this new ethos, it comes as little surprise that the Church of St. Andrew, home to New York City's first pet cemetery, plans to open its human cemetery to creatures so that pet owners can be buried near their animals.

Michael Kearl

See also Funeral Conveyances; Funeral Industry; Grief, Types of

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Cemeteries, Unmarked Graves and Potter's Field

Cemeteries are physical places where bodies are laid to rest according to the laws, regulations, traditions, and rituals of their particular culture or religion and, typically, according to the wishes of family members or next of kin. Most burial places are marked in some way for perpetuity, the simplest markers bearing name, date of birth, and date of death. Lost in this conception of cemeteries are an unknown host of individuals who over time have been laid to rest in unmarked and later unknown graves, sometimes in mass rather than individual grave sites. These dead are unidentified, unknown, or unwanted in death as they likely were in life. Unmarked graves result from one of two sources. The first includes various kinds of natural or man-made disasters that claim lives in such numbers or in such form that the dead cannot be identified, for example, wars, hurricanes,

floods, or fires, circumstances that can even dictate the necessity of mass graves. The second source of the unknown dead includes the outcasts of society or those who were so unimportant in life that they receive no notice in death. Such persons often die in public institutions, or their remains become public responsibility because they could not be identified or were unclaimed by family or friends, often for lack of funds needed to dispose of the body.

Some countries do not regulate disposal of the dead or may suspend regulations in times of national crises or disasters when bodies are buried in unmarked plots, sometimes in mass graves, or burned. In the United States and many other industrialized nations, municipalities or other levels of governance have found it necessary to maintain burial space for persons who die in their custody or care or whose remains are left to that entity by default. In keeping with the traditions of Europe and America, bodies have more often been buried than cremated, thus creating the necessity for public or paupers' cemeteries, sometimes known as potter's fields. The origin of the name is apparently located in biblical history as recorded in the Gospel of Saint Matthew (27:7). A contrite Judas, having betrayed Jesus, returned his reward of 30 pieces of silver to the chief priests who judged it illegal for "blood money" to be returned to the treasury. They decided to use the money to purchase a burial ground for "foreigners." The land purchased is thought to be a site in the valley of Hinnom that was a source of potter's clay and sometimes referred to as "the potter's field." Hence to the present time, public burial spots for the indigent or unclaimed are often known as "potter's field."

Potter's fields have become the final resting places of those whose remains were never identified along with those who died in prisons, hospitals, almshouses, workhouses, orphanages, in isolated medical colonies or other public facilities that warehouse individuals. Some of the first municipal or institutional cemeteries, both in the United States and in Europe, were pauper's cemeteries where graves were unmarked or the markers did not stand the test of time. In some cases, cities, prisons, or other public agencies keep a record book containing plot and grave numbers as well as such vital statistics as were known about the deceased: age (or approximate), date of death, cause of death, place of death, and date of burial. Pauper's cemeteries were located on public lands that over time were often claimed for urban growth or municipal projects and the graves moved. The City of New York, modeling practices in England, had one of the earliest Pauper's Fields in at least nine different locations before purchasing Hart Island in 1869. The island now contains over three-quarters of a million unmarked graves prepared and maintained by prisoners from nearby Riker's Island who, without rites, bury coffins three deep. Records are kept by name (if known), sex, date, plot, and section in the event of future exhumation. The only marker in the Hart's Island cemetery is a 30-foot high monument in the center of the burial ground engraved with a simple cross on one side and the word "Peace" on the other.

Historically, unmarked graves result from disasters and wars where the sheer numbers of the dead necessitate speedy, and at times, mass burials, for example, following the recent Asian tsunami in the Indian Ocean. Before rapid transportation, storage facilities for the dead, and DNA or other medical testing, war made the battlefield the burial ground for many soldiers. Even in battle, however, except perhaps the case of Indian massacres such as at Wounded Knee, South Dakota, in 1890, the United States has rejected in principle the idea of mass graves. As late as 1980, the Veterans Administration, in an effort to create space in national cemeteries, announced a plan to exhume the bodies of 627 unknown war veterans to be buried and memorialized in a mass grave. The plan was scrapped due to political protest.

Although the use of mass burials, unmarked graves, and pauper's fields is no longer widely practiced in most developed countries, historical circumstances related to disaster, marginalization, and poverty still dictate the burial of the unknown or unidentified dead in impersonal and anonymous ways. Pauper's cemeteries and battlefield memorials stand as monuments to a society's beliefs about death and represent at least a minimal acknowledgment of public deference to death as the last and great equalizer.

Vicky M. MacLean and Joyce E. Williams

See also Cemeteries; Cemeteries, Virtual; Memorials; Memorials, Roadside; Spontaneous Shrines; Tombs and Mausoleums; Tombstones

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Cemeteries, Virtual

A virtual cemetery is a database search term identifying a wide range of cemetery-related interests on the Internet. They include cemetery locations, cemetery records, headstone photos, tours of local and historical cemeteries, burial sites of the famous, and online memorialization of the dead. Related sites deal with end-of-life controversies, consumer rights, death humor, genealogical information, unusual techniques of body disposal, and commercial services including rental caskets and help in composing a eulogy. An Internet search identifies over 250,000 sites on one search engine and over 7 million on another. More specifically, virtual cemeteries are sites at which survivors post online memorials and where family, friends, and the merely curious visit and leave comments. Posting a memorial at some sites is free, others charge a nominal fee, and typically there is an index or grid to help the user find a specific memorial. Judging by the number of visitors, virtual cemeteries are busy places. This entry describes a typical site, suggests reasons for the popularity of these memorials, and identifies those most likely to be memorialized on them.

Cyberspace Cemeteries

There are many cyberspace cemeteries with many thousands of posted memorials and millions of so-called reflections attached to them. Reflections for any one individual often number in the hundreds. There are many common features to these postings. Typically the site opens with a photo and a quote such as from an inspirational book. Several click-on buttons are used to direct the reader to a biography, perhaps a set of photos, and a section in which comments may be left by visitors to the site. Anyone can read these messages, but they are often required to enter a name, e-mail address, and location before posting comments. Some of these messages may be addressed to the family, some to the deceased, and others to the world at large. Many such comments pertain to the attractiveness and meaningfulness of a memorial, whereas others can best be described as narratives of shared grief.

Many who purchase online memorials check them regularly, even daily, to read the newest posting. In so doing, some users have discovered relatives they did not know they had and found friends long out of touch. Many say they learned new things about the deceased. An electronic community of family, friends, and strangers is thus created and, according to some site operators, these networks sometimes continue as old friendships are renewed and new ones formed.

Virtual cemeteries for pets are also common, and they are filled with memories and expressions of love as compelling as those posted for people. Like human sites, they contain commemorations, poems, and photographs, and, like human memorials, those for pets are funny, sad, and touching. The memorialized include cats and dogs, of course, but also turtles, birds, horses, and in one instance a collection of snails. Animals are as missed as people and in the electronic public square that a virtual cemetery is, their absence is as mourned as that of any person.

Explanations for Popularity of Cyberspace Cemeteries

There are various explanations for the recent popularity of these cemeteries. First, contemporary families are scattered and mobile, and e-mail and shared digitalized photos are a logical preliminary for those inclined to go the next step and create an online memorial. Second, more people now choose cremation and scattering ashes, a practice that leaves survivors without a tactile place to pay tribute, to communicate with the dead, or to imagine a loved one resting nearby but residing in a better place. Third, the heaven of the Western imagination has always been a utopia populated by beings immune to the effects of earth, air, fire, and water, and, appropriately, the texture of its cyber equivalent is a weave of ones and zeros, the lightest of conceptual particles, a suitably modern image for escape from the

degradation of physicality and decay. The seeming miracle of it, some have noted, is that as cyber presences, the dead can be addressed directly in the perfected electronic ether they inhabit. Technologically revolutionary, cyberspace is yet mythically and poetically familiar, a new venue for expressing traditional themes of hope, resurrection, and safety.

Content studies of memorial sites have shown that infants and persons under age 18 are common in the postings, their unexpected deaths apparently creating a special need to say something about them. The average age of memorialized adults is fairly young, 52, while the elderly, whose deaths are more expected, are less commonly listed. Men are more likely to be memorialized online than women, at some sites by large margins. Cancer and accidents are the most commonly cited causes, AIDS and suicide mentioned less frequently. The degree to which nonwhite communities are represented at these sites is unclear. Most postings address a general audience of readers, following the style of newspaper obituaries, although nearly a third are specifically addressed to the deceased. Those intended for the wider community usually are written in a "storytelling" style that recounts life events, adventures, employment history, hobbies, and the deceased's impact on the lives of others—the familiar "celebration of a life" of most eulogies. Messages directed to the deceased are more likely to be written by women and are in letter format, conveying personal information about the sadness of the author. Few of these postings deal explicitly with religion beyond expectations that the deceased is in heaven and well cared for. While memorial sites are places for family and friends to visit, they also attract those described in the literature as "disenfranchised grievers," lovers, partners, classmates, and coworkers. The participation of these people in shared memorialization has been notable in instances of death from AIDS. The web makes possible public mourning from sources families may not expect.

Memorial websites appear to generate real, if unconventional, communities. Those who log on to read a particular memorial frequently "wander" through the cemetery looking at other sites as well. Shared sympathies from strangers who have experienced a comparable tragedy are common, and they have led to online friendships, particularly among those mourning a child or young adult. According to one site operator, mothers who posted a child death or teen suicide subsequently organized themselves to scan postings for similarly suffering parents. E-mails of support and encouragement were then sent by the group. Virtualmemorials.com makes this relatively easy as a search through the reflections can be limited to specific categories of persons—infants, young children, teens, siblings, spouses, adult sons and daughters—enabling users to quickly find memorials to losses similar to their own.

Cyberspace Model of Grief

As sites of bereavement, virtual cemeteries are a new and vigorous phenomenon, and they exemplify a newer model of grief, one called "continuing bonds." The etiquette of grief in English-speaking cultures has historically favored emotionally contained, self-focused suffering. That view, in part a descendent of the theories of Freud and popularized by Elisabeth Kübler-Ross in her stage theory of grief, characterizes bereavement as therapeutic labor or grief work in which the bereaved are counseled to separate themselves from the pain of their loss and seek closure so they can "move on." Continuing bond theorists argue instead that grief is never really "resolved," and total separation from one's dead is not possible or even desirable. Rather, the bereaved do their grief work by reviewing what the dead meant to them while alive and, equally important, they do that in the company of others who also knew the deceased. The task is to create a new relationship in which the dead—as role model or perhaps as agent of values clarification—is part of the survivor's future. That can be done in private reflection, but communal exchanges with interested others are equally important. Monologues at grave sites, reports of ghostly sightings of the deceased, stories told and elaborated at family gatherings or in support groups, and reflection on how the dead would have responded to some new challenge are all acts that build a continuing bond. The therapeutic task is both private and social, consoling but also educational, and out of that a more nuanced picture of the absent individual emerges, an image richer than the memories of any one person. In a postmodern society lacking standardized rituals of

death, virtual memorials are one way of creating continuing bonds through an electronic community of web users who comment on one another's grief. The posted narrative of a life can be continuously expanded and revised, each contributor to the story bringing a slightly different perspective. No closure is needed as the story line is a continuing project, growing with each addition to the reflections page. Cyberspace enables grief work but in a new and still evolving way.

Cyberspace Religion

Virtual cemeteries are themselves embedded in a larger, and also recent, phenomenon, that of cyberreligion. The key illusion of cyberspace, according to some researchers, is that, like a god, the Internet is always available to the faithful. It hears (or at least absorbs) every request and, like a loving parent, gives singular, unwavering attention to each person's expressed needs. This conveys a quasi-mystical sense of omnipresence and timelessness, even mystery, which contributes to the hope that the dead really do receive the electronic messages addressed to them. Memorialization as restorative ritual is one subset of online religious expression, which includes the convening of spiritual communities, discussions of cyberheaven, warnings of the apocalypse, and appearances in cyberspace of religious apparitions. In this context, virtual cemeteries are not the isolated curiosities they might at first seem.

Dispersed families and geographical mobility are prominent features of globalization. So too is the decline of dominating religious traditions and their rituals for escorting the living from this life to one somewhere else. Virtual cemeteries are a response to these newer realities, congenial public places for reaching out to others, even to the dead themselves who live on as valued cyberpresences among the living.

James W. Green

See also Bereavement, Grief, and Mourning; Cyberfunerals; Memorials

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Cemeteries and Columbaria, Military and Battlefield

Both cemeteries for the burial of the dead and columbaria for the preservation of cremated ashes shift their meaning in the context of conflict, especially those wars fought in the name of the modern nation-state. Within Europe, mass death far from home prompted a shift in commemoration of the dead of war, a militarization, in effect, of mourning practices that witnessed changes in the structures of civic cemeteries and the construction of national cemeteries and commemorative sites following the American Civil War (1861–1865), the Franco-Prussian War (1870–1871), and World War I (1914–1918). In the absence of bodies, new rituals focused on the meaning of the death, on sacrifice in the name of the nation, and on the extension of national sacred sites abroad, especially following World War I.

The problem of the absent body did not arise with World War I, and hardly terminated with it; yet it is that conflict that dominates, to a great extent, any and all discussion about battlefield death, its commemoration on the battlefield itself, in cemeteries proximate to or far from said battlefield, in columbaria—broadly conceived—and in monuments. Ever since Philippe Ariès identified World War I as the conflict that witnessed the peak of the "civic cult of the dead," scholars and popular writers alike have tended to interpret the response to death in battle in the context of the years 1914–1918, with the rituals attendant upon

soldier sacrifice as precursors to or developments from that war to end all wars.

Battlefields are contested spaces in more than one respect; military contests upon them are frequently followed by political conflicts over their transition from sites of military exchange to sites of mourning and, ultimately, to sites of memory. Although much of the controversy surrounding battlefields derived (and derives) from war's relationship to the nation-state, the message conveyed via war commemoration predates the formation of modern nations. Even in the 15th century, Europe's battlefields represented politically charged sites on which memorial chapels were erected to establish the power of the victor and control the memory of the vanquished. With the nation-state, of course, came more elaborate and more consciously constructed sites of memory, which encompassed both ritual responses to the sacrificial dead of war and architectural statements in the form of cemeteries and associated monuments of the power of the nation in whose name so many had died.

The pattern that many such commemorative cemetery sites followed echoed, in certain respects, the "rural" or "park" cemetery movement that emerged on both sides of the Atlantic in the early 19th century largely in response to the example of Père-Lachaise (1804) in Paris. London's Kensal Green (1833), the Glasgow Necropolis (1832), and Mount Auburn in Cambridge, Massachusetts (1831), offered the most notable early examples of the repositioning of death in a rural setting, one designed as much for the moral uplift of visitors as for the emotional succor of the bereaved. Furnished with guidebooks, visitors were encouraged to admire these new "gardens of graves," and to derive spiritual solace from them. This was a period during which the cult of the dead found its fullest expression, but in terms of the relationship between the dead and the living, it was also one that had lost the coherence of community. In this context, the rural cemetery movement did not merely satisfy emotional and moral needs but also served a nationalist, patriotic function. An important link was forged between the land in which the dead were buried and the mourners—a link that prompted both patriotic and personal responses. This found its fullest and most potent expression in the military cemeteries that were constructed following the American Civil War and, in slightly different form, in Europe after the Franco-Prussian War and World War I.

On the Altar of the Nation

Post–Civil War American military cemeteries presaged, in some respects, the national cemeteries of World War I, yet there are differences, alongside the overt visual similarities, in the responses to the dead in each case. What the American Civil War highlighted most clearly was a sea change in attitudes toward the citizen soldier, whose death in the cause of the nation provided a patriotic and political dimension to the ceremonial response to the fallen. The Napoleonic Wars in Europe had produced death on a mass scale, and common graves were often the final resting place for many soldiers. Such deaths did not go unacknowledged; indeed burial at all was regarded as better than the alternative of simply being abandoned on the battlefield, and the attempt within the ranks to provide a Christian interment for fallen comrades, however rudimentary, was testament to the importance accorded burial rites in this period. As in Europe, however, in America, most notably in the Mexican War (1846–1848), official ritual interment for the nation's soldier dead was neither feasible nor understood as necessary; although a memorial was later erected in Mexico City, the remains were, by that point, unidentifiable.

The Civil War witnessed a shift in the treatment of America's soldier dead, once it became obvious that the war would be neither brief nor relatively bloodless. Two months after hostilities commenced in 1861, the War Department stipulated that all deaths be properly recorded and graves appropriately marked. The following year, it was further stipulated that ground proximate to the battlefields be purchased in which to bury the dead. In 1862 alone, the federal government established no fewer than 14 national cemeteries, some at troop concentration points, some at prewar post cemeteries, others proximate to battlefields, such as Antietam and, most famously, Gettysburg. In fact Gettysburg was, from its inception, much more than a simple cemetery. At its dedication, statesman and orator Edward Everett—himself instrumental in the creation of Mount Auburn—emphasized the classical parallels between this New World ceremonial cemetery and Athenian precedent, specifically the law stipulating that

soldiers who fell in battle be accorded full honors and buried at the public expense. This set the tone not just for the symbolic shrine that Gettysburg would become but for the popular understanding of the role played by the Civil War dead in the nation.

The obvious parallels between Gettysburg and the form and development of cemeteries during the French Revolution and the wars of liberation and, later, World War I are not simply visual. The rows of identical grave markers were designed to symbolize the equality of the fallen in the republic, in America as in France, and became the style adopted for all national cemeteries in America, for American cemeteries to the war dead in Europe, and for many European cemeteries.

Gettysburg also followed the rural cemetery precedent, both in its form and in its function as a site of consecration for the land itself. As with rural cemeteries, Gettysburg became a tourist attraction, and visitors were encouraged to consider the power of the American republic in whose name the men interred there had died. The cult of the fallen Civil War soldier became a constant element in American sacred ceremonies and in the monuments erected over the years, not just in remembrance of the Civil War, but of other wars, too, most notably in the nation's capital. Washington, D.C., as Ariès pointed out, has become over time the central sacred site of the nation; an entire city suffused with the ghosts of the dead of war, the many memorials erected there—notably the Vietnam Memorial—are responded to as tombs, and treated appropriately, with flowers and mementoes inserted into the gaps between the slabs listing the names as they might be placed on an individual grave.

Contested Commemorations

Sites such as the Vietnam Memorial, which function symbolically as tombs but are absent bodies, represent a form of columbarium, but columbaria themselves have become more significant as sites of militarized commemoration in response not just to the growing numbers of war dead—and eligible family members—but to the right of all honorably discharged military personnel to have an official state burial. Military columbaria, in the United States, clearly reinforce the link between military service and national citizenship, and place the dead in a national, historical, and military context, as the national cemetery at Los Angeles, with its display of military uniforms, makes clear. In such cases, the issue is not absent bodies, but a reinforcement of the national body.

Military cemetery at Gettysburg

Source: Susan-Mary Grant.

In this context, one of the most contentious military sites of memory is the Yasukuni shrine in Japan, similar in some ways to sites such as Gettysburg in that it was a product of the modern nation-state, reinforcing patriotism by emphasizing that the war dead achieve both state and spiritual acknowledgment. Yasukuni functions within the framework of Japanese religious belief; although there are no bodies at the shrine, the spirits of the dead are understood to be present in a more tangible form than in any American or European memorial, and priests function as the intermediaries between the living and the spiritual world. The mutual dependence between the dead and the living at Yasukuni is therefore mediated through a belief system apparently absent in America and Europe; yet the difference may be more apparent than real, both in terms of the political and national controversies surrounding sites such as Yasukuni and, more fundamentally, in the naming of the dead as an intrinsic part of the ritualized representation of remembrance at war cemeteries, columbaria, and memorials generally.

Much of the controversy surrounding Yasukuni relates to the "burial" there of war criminals and, in a broader sense and partly through its associated museum, the shrine's perceived reinforcement of aggressive militaristic values inappropriate to modern Japan. Directly equivalent controversies may not attend other sacred sites, but the issue of who is commemorated, and to what ends, in war cemeteries and battlefield memorials informs the development and meaning of such sites worldwide. In Spain, the Valle de los Caídos contains the dead of both sides, Republican and Nationalist, from Spain's civil war, but the presence of Franco's remains dominates, diluting, to a degree, the reunification message intended by the construction of the basilica. After America's civil war, only the Union dead were interred in the new national cemeteries; the exclusion of Confederate dead was an understandable, but ultimately divisive, statement of national belonging. The separation of African American Union troops from white troops in such cemeteries sent a rather different message about citizenship and its costs, but a context-sensitive one; the corner of a foreign field that is forever America, namely the military cemeteries for the American dead of World Wars I and II, did not follow a similar pattern of segregation.

War cemeteries in general, Julie Rugg has argued, frequently recall the horrors of war rather more than the individual dead, but such a stark distinction between individual and national commemoration is misleading in the context of the wars fought by the modern nation-state. The evolution of many battlefields, such as Gettysburg, into National Military Parks in the later 19th century, and the concomitant growth of battlefield tourism in the 20th, particularly following World War I, blurs any clear distinction between the pilgrim and the tourist, the personal and the overtly political, and sacred sites cater to both. In the aftermath of American Civil War battles, noncombatants scoured the battlefields, many in search of the missing but others seeking to collect some *memento mori* in the form of a bullet, a button, or even a bone to take home. The strict regulations that are in place today to protect battlefield sites from relic hunters highlights the fact that if war has a price, it also has a value.

The value of the sacred sites of war, for those less materially inclined than relic hunters, lies in their liminality not just between the living and the dead but between the individual and the collective and, for many, between the homeland and the foreign field. For those whose family members died abroad and whose remains were not repatriated, for those whose dead were never identified, the name on the Menin Gate, the "Unknown" tombstones at Gettysburg, or the flimsy piece of paper at Yasukuni may condole as much as commemorate; in this sense the war cemetery, like the rural cemetery before it, provides personal space within a broader patriotic context, encourages rumination alongside remembrance, and positions both in an environment designed to contain and control the death, and responses to it, resulting from war.

Susan-Mary Grant

See also Cemeteries; Columbarium; Memorials, War; War Deaths

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Childhood, Children, and Death

The issues surrounding how children understand and respond to death have profound implications for their healthy development into adulthood. Multiple factors influence their cognitive understanding of death, including chronological age and developmental capacity. How well they will cope constructively with losses in childhood is a complex combination of internal and external forces, with important implications for professionals and parents.

Scholarly commentary on children's understanding of, and reactions to, death reaches back to the 1930s and 1940s, with the publications of Paul Schilder and David Wechsler, Sylvia Anthony, and Maria Nagy. How and when children develop a mature understanding of the finality of death, how their reactions and responses differ from those of adults, and what methodologies best accommodate them in healthy grieving are topics that have received increasing interest in the research and clinical communities in the past 3 decades.

Child's Understanding of Death

Most discussions of children's understanding of death begin with the models of childhood development of Erik Erikson or Jean Piaget and the characteristic tasks inherent in subsequent stages of development. It is generally accepted that by the age of 7 years, most children have a mature concept of death. It has long been thought that a mature concept includes the four components of (1) universality, the fact that everyone dies, that death is the inevitable end to every living being's life, and that it is unavoidable; (2) irreversibility, the understanding that once you are dead, you cannot come back to life; (3) nonfunctionality, that when people die they can no longer engage in biological activities like eating, talking, breathing, walking, or laughing; and (4) causality, that death happens because of certain and identifiable biological reasons.

More recently, two additional concepts have been proposed, by Lynne Ann DeSpelder and Albert Lee Strickland, and Mark W. Speece and Sandor B. Brent, respectively. Those concepts are personal mortality, the realization that "I will die too," and noncorporeal continuation, the nonempirical notion of some kind of existence beyond the physical.

From birth to approximately 2 years of age, corresponding to the sensorimotor period in Piaget's model of cognitive development, the child is developing senses and motor abilities and begins to build bonds with what John Bowlby referred to as the "mother-figure." Pioneering work on loss and attachment by John Bowlby and others about infancy and abandonment laid the groundwork for a clearer understanding of how deeply infants and very young children understand, if not *death,* at least *goneness*.

Piaget's preoperational period includes ages 2 to 4, a time of intense egocentric thought, and ages 4 to 6, when more socialization, speech development, and problem-solving abilities develop. During this time many children become curious about and interested in death, through the experience of insects and animals, cartoons and children's books, or the deaths of pets or grandparents. While struggling with a comprehensive understanding of the finality of death, it is not unusual for children this age to engage in "magical thinking," that is, the belief that their actions contribute directly to events that objectively they cannot control. They may believe they "caused" someone to go away and, subsequently, that they can "cause" the person to return.

Around the age of 7 through age 12, during what Piaget calls the concrete operational period, children's understanding of the death concepts is generally mature, though the operational tasks of this age provide a challenging time for incorporating the death of a parent or sibling into the normal growth experiences of building competency, comparing oneself to others, and valuing peer relationships.

Finally, entering the formal operational period at age 12, the adolescent's tasks and challenges of individuation and independence emerge in force, and peer relationships take on primary concern in the child's world. It is important to remember that coping with the death of a person who had a primary relationship with a child or adolescent—a parent, sibling, or close friend—is not an event but rather a process. The grief will be reexperienced throughout the phases and periods of the child's development and well into adulthood, when the early loss of a parent may become acutely experienced through pivotal events like graduation and other successes, dating, marriage, raising one's own children, and turning the age of the person who died.

Influences on Children's Reactions to Death

In addition to the child's developmental and chronological age and capacity for understanding a mature concept of death, other issues will influence how children respond to death. An important influence is the social context in which a death takes place. Bill Worden and Phyllis Silverman, in the Harvard Children's Bereavement Study results, emphasize that after a parent's death, one of the strongest predictors of how a child will cope is the emotional and mental health of the surviving parent. Other social factors influencing the child include what other support systems are available; how friends and peers respond; and what level of social engagement, belonging, and competence the child has through athletics, clubs, religious affiliations, and other activities.

The preexisting relationship of the child to the deceased is an important and often underemphasized aspect of how a child will cope. If the relationship was conflictual, death does not resolve the conflict; if the last communication between the deceased and the child was problematic, the possibility of resolving the relationship strain is no longer viable; and often, at all ages, children and adolescents often continue to believe that their behavior in some way contributed to the death. In cases where the child's actions contributed to the death, through an accidental shooting, for example, the normal complications of grieving may be exacerbated.

Other possible complications to how children may respond include witnessing the death, facing the stigma of suicide or violent death, dealing with the absence of a body, and all of the secondary losses that may accompany such a loss. These may include changes like moving to a new home, losing friends, questioning prior beliefs about God and the nature of one's personal safety, divorce, and shifting to a new school, among others.

Children's Versus Adults' Grief Reactions

Typical, normal responses to grief include emotional, physical, spiritual, relational, and psychological aspects. Emotions may include sadness, anger, relief, frustration, rage, guilt, and the full range of expression or repression of these, in accordance with the child's personality, intelligence, experience, and developmental age. Often young children in grief show regressive behaviors like bedwetting, crying when left, returning to wanting a bottle, or wanting to be held like a baby, though these effects typically decrease with time. Physical manifestations may include headaches, stomachaches, pains or aches for which no physical cause may be found, difficulties sleeping or eating, and conversely, overeating and oversleeping, as well as difficulty concentrating, staying focused, and attending to tasks. The experience of grieving may be isolating as adolescents withdraw from friends who don't understand or don't provide helpful consolation, and they often challenge and question assumptions made about personal safety, the meaning of life, and the existence of a benevolent God.

In a society that urges grievers to "move on" or "get over" grief, children's and adolescents' need for memorialization, meaning-making, and continuing bonds with the deceased are often overlooked by the adults around them. Additionally, growing professional interest in pathologizing the experience of grief has led to unrealistic expectations of the expected duration and intensity of grief symptoms, particularly among youth.

Whereas models for how adults grieve have proliferated and include tasks of grieving, phases

of grieving, as well as Elisabeth Kübler-Ross's much abused and overgeneralized notion of "stages of grief," models of how children grieve have relied, for the most part, on the developmental stages and periods of Piaget and Erikson discussed earlier. As a result, there has been a lesser understanding of the differences between how children grieve and how adults grieve.

Because children's expressions of grief are so intertwined with their understanding of death and their continuing developmental processes, integrating death into their lives appears to be an ongoing process, hence longer in duration than that of most adults. Additionally, children have less life experience and more limited developed means to make sense of death and often fewer tools with which to express themselves. They tend to be more sporadic in their grief responses than adults—that is, seemingly in and out of the intensity of feeling, one minute crying and the next wanting to join friends for a basketball game.

Parental Death

More research has been conducted on the impact of parent death on children than sibling or friend death, most likely because it is more commonly experienced. Most studies have been retrospective, and there is a wide range of research and practice-informed literature addressing the effect of early parental death. Because of the variety of factors influencing how children may respond to a parent's death as discussed above, it is impossible to conclude that all parentally bereaved children will suffer traumatic consequences as a result of the death. Numerous studies, however, refer to parentally bereaved children's increased vulnerability for risk of depression, anxiety, and relationship issues, among other symptoms. Conversely, psychologists like Richard Tedeschi and Lawrence Calhoun, who coined the term *post-traumatic growth* in 1995, point out opportunities for growth even among the most potentially traumatizing of events.

Sibling Death

Although the occurrence of sibling death in childhood is less frequent than that of parental death, and much less research has been conducted on the potential longer-term outcomes, it is generally agreed that the death of a sibling may bear a significant impact on surviving siblings. As with parental death, the response of the surviving parents is a pivotal influence on the surviving child or children. One aspect of sibling death that often heightens, as opposed to parental death, is the frequent sense of guilt among children that they were permitted to live while the sibling was not. Betty Davies has studied and written extensively about the long-term effects of sibling deaths in childhood.

What Children Need

In 1980 John Bowlby proposed four factors that facilitate a child's ability to mourn, and though they have been further expanded by clinicians throughout the years since, they remain a solid foundation from which to understand how to best assist children following a death.

The first factor, and the only one that cannot be retroactively controlled, is having a secure relationship with parents before the death occurs. Children who have experienced multiple losses, including divorce or abandonment, or whose lives include substance abuse, violence, physical abuse, and instability, stand at greater risk for future difficulties without that solid foundation of security, love, and support with which to manage living in the wake of death.

Second, Bowlby advocated that children fare better when they receive prompt and accurate information about the death. Often in an effort to "protect" children, adults do not share information honestly, especially if the death is a stigmatized death like suicide, AIDS related, or homicide. Children frequently attune to the reality that the truth is being withheld, they intuit from others that the story they have is not the full one, and/or they hear through other children or the media about the actual circumstances of the death. For these reasons, and because having the truth and not having to "fill in the blanks" allows children to begin to regain a sense of personal control, they should be told the truth by a trusted adult, as soon as possible, in ways that are developmentally appropriate and in language they can understand.

Participation in the social rituals around the memorialization of the life and disposition of the

body of the deceased is the third factor that facilitates a child's ability to mourn. Because a death inherently changes the lives of those mourning the loss of the person, having choices around designing and participating in rituals such as casket selection, funeral or memorial rituals, and where and how the body will be disposed help children feel a part of, rather than excluded from, these social networks and decisions.

Finally, Bowlby's fourth factor is having the comforting presence of a parent or parent substitute after the death. Studies of resiliency and children frequently refer to the importance of adult parent-figures or mentors in the lives of at-risk youth.

Robert Neimeyer, Daniel Siegel, David Crenshaw, and others have more recently placed emphasis on the healing power of meaning-making, in which children are supported in developing coherent narratives around what happened, and the meaning they derive from their experiences following a loss through death. An additional aspect of the meaning-making is the reality that change occurs in a social context; that is, our neurobiology is affected through the interchange with others.

Normal Reactions Versus Trauma/PTSD

Considerable focus by researchers and clinicians in the early 2000s has centered on the issue of trauma and post-traumatic stress disorder (PTSD). The diagnostic criteria refer to symptoms emerging from emotionally traumatic experiences, with three main clusters: intrusive and unwanted flashbacks or nightmares, in which the traumatic event is reexperienced; avoidance, such as when the person actively avoids exposure to people, places, or things that might trigger intrusive symptoms; and hyperarousal, evidenced as increased physiological arousal such as hypervigilance or a trigger-pin startle response. While it is generally accepted that early traumatic experiences may have long-term consequences, there is less clarity on what defines a traumatic experience. For example, some children exposed to violent deaths, suicide deaths, and/or other seemingly traumatic events may not show symptoms of PTSD or trauma, indicating that it is not the event itself, but rather, the perception and meaning-making of the event that engenders trauma symptoms. Judith Cohen and Anthony Mannarino coined the term *childhood traumatic grief* to describe the condition in which trauma symptoms interfere with a child's ability to engage in a normal grieving process, and this model implies the need for professional intervention to address the trauma aspect and symptoms and reduce the risk of future psychopathology. More research is needed to determine under what circumstances children experiencing loss through death may develop trauma symptoms, as well as the evidence for effective treatment models.

Research and Interventions

Increasing interest in possible long-term effects of unaddressed childhood grief has led to widely disparate stances on the efficacy of therapeutic interventions. In the early 1980s a burgeoning number of children's grief support programs developed, now numbering in the hundreds, networked through the National Alliance for Grieving Children. Significant contributions to the field of knowledge have been developed through the research of Phyllis Silverman and J. William Worden, Irwin Sandler and researchers at the University of Arizona, among others. Much more research, however, remains to be conducted, particularly on intervention methods. In a meta-analytic review of controlled outcome research in 2007, Joseph Currier, Jason Holland, and Robert Neimeyer were able to locate only 13 studies that included a control group and quantitative measures. One of the major obstacles to research is the lack of a well-validated measure of childhood grief.

Donna L. Schuurman

See also Adolescence and Death; Bereavement, Grief, and Mourning; Defining and Conceptualizing Death; Kübler-Ross's Stages of Dying

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Chinese Death Taboos

Chinese people share a long history of poverty, famine, disaster, plague, and political unrest where death was commonplace and the living had few, if any, effective ways of protecting themselves from it. Their anxiety and fear of death and dying are manifested in a wide range of taboo behaviors that are prescribed by traditional wisdom. Social anthropologists have suggested that death taboos and rituals have contributed to the homogeneity among Chinese populations both over the centuries and across oceans in the Chinese diaspora. These beliefs may be changing among younger, educated Chinese people, but on the whole they remain strong and influential.

The common taboos include not talking about death; having no contact with sick and dying people; avoiding proximity to coffins and dead bodies, including their clothing or belongings; and not mentioning the names of dead people for fear of calling back their spirits. Contact with family members of the deceased is avoided, as they are believed to be ritually polluted and the bearers of ill luck. In general, the curtain that divides the living from the dead in the Chinese world is flimsy and permeable and the belief in spirits and their capacity to affect the living for good or bad is widespread. It is not surprising that a varied and complex system of beliefs and rituals has developed to ensure that the dead stay on their side of the curtain.

Death Pollution

All mortuary rites are regarded as unclean, unlucky, and contaminated by evil, so the living must adopt precautions against their influence. Bathing after returning home from burial rituals serves to purify the living from the polluting effects of death. Blankets, clothing, and personal belongings of the deceased, as well as mourning outfits, will all be burned. These rituals of cleansing and the shedding of mourning clothes may also serve to control infectious diseases.

Corpses are thought to pollute everything and everybody in their vicinity, and this pollution and the ill luck that accompanies it can be passed on by secondary contact. Grieving family members are encouraged to stay at home and not to visit others' houses for 100 days after the death. Traditionally, a white (the mourning color) lantern would be hung outside a house where a death had occurred to warn passersby. This sense of being polluted and contaminated can mean that the bereaved become isolated and are denied comfort and support when they need it most. Ignoring the taboos means risking being blamed for the bad luck, illness, or death that may befall anyone with whom they have had contact.

Rituals to Reduce the Harmful Influences of the Dead

Natural deaths may lead to haunting and evil deeds by ghosts, even family members. A corpse, if kept at home, is placed in the sitting room with feet facing the door so that should it rise as a vampire, it will walk straight out of the door instead of harming family in the home. The date and place of burial are carefully selected for the salvation of the soul and to promote smooth reincarnation so that the spirits will move on. Offerings of food and spirit-money are made to appease any wandering spirits at the funeral. Elaborate funeral and mourning rituals dictate when to cry loudly, who to invite, what

to put into the coffin to accompany the corpse, music, religious chanting, dress codes of family members, and food to serve. Paper representations of worldly possessions such as mobile phones, cars, iPods, and clothes, for example, are burned so that they follow the deceased to the spirit-world where they will be available for his or her use. What these objects are depends on standards and content of consumption in that particular community. Ideally, grave sites should be carefully selected with good feng-shui that will bring luck, health, and prosperity to children and grandchildren. However, for many decades cremation has been officially encouraged in China because of the fear of losing arable land to burials.

Unnatural Deaths

Death without a proper burial is regarded as an eternal curse in the Chinese culture, as the spirit cannot be reincarnated. Unnatural deaths due to accidents, suicide, violence, lightning, and miscarriage are regarded as the consequence of past sins. Such deaths are a form of punishment for one's own wrongdoing or are seen as the sins of the ancestors being visited on descendants. Spirits resulting from unnatural deaths are believed to be particularly vicious, revengeful, and likely to kill to seek reincarnation. Corpses resulting from an unnatural death cannot be brought back home, and no funeral will be held. Their loved ones live with fear, despair, stigma, and social discrimination.

Taboo Words

The ancient Chinese believed that the spirit of a thing resided in the symbol or word that represents it. Thus people could be influenced by the utterance of words or the manipulation of symbols. A word is likely to be a taboo if it represents something that is regarded as sacred, dangerous, or contravenes the natural order.

Linguistic taboos have existed since the Zhou dynasty (1050–771 B.C.E.), that is, 3,000 years ago. *Death, illness, ghost, funeral, graveyard, corpse, grief,* and *death rituals* are all taboo words thought to bring bad luck. Even thinking about death may awaken harmful evil spirits. In consequence, it is difficult for Chinese people to prepare for death, both their own and that of others. Life insurance is also treated as a taboo, and the percentage of Chinese people who are insured is relatively small. Because many do not write a will, family lawsuits regarding inheritance of the estate are frequent.

Naturally, there are countless euphemisms for the word *death* in Chinese, for example, "gone to the West Heavens," "nailed the lid" (7 nails to seal the coffin), and "reported for duty (to the Emperor of Hell)." Homonyms also abound; the Chinese word for death sounds like the word *xi* (four); thus, the number four is taboo. Buildings often have no 4th, 14th (sounds like "sure dead"), and 24th (sounds like "die easy") floors in buildings, especially office towers, hospitals, and hotels. In traditional mourning rituals, 7 is the number for ghosts. Deceased persons should be served with seven dishes of food in offerings. He or she will return to their home on the evening of the 7th day after death. The spirit of the ghost will have to be reincarnated within 7 × 7 days (49). When Chinese prepare their meals or order dishes in restaurants, they will either have six or eight courses, never seven.

Even with a plentitude of euphemisms, Chinese are reluctant to talk about death or even illness, especially when the illness is life threatening or terminal. Thus, hospice or palliative care and advanced directives are often refused because it would mean thinking and talking about death. The family may be panicking and deeply distressed but will still be reluctant to discuss the issue of an advanced care plan with their loved ones.

Final Judgment in Hell

Everyone who dies must face the final judgment of the Emperor of Hell, flanked by his ox and horse-faced guards. All life's misdeeds will be punished before reincarnation can take place. Family members have to chant and burn paper offerings for the deceased to ensure that he or she can "buy their way through" hell and be reincarnated. The image of hell is much stronger than the image of heaven among the Chinese. The horror of death and the image of hell are firmly established in the minds of Chinese people because of Daoist (Taoist) and folk teaching. Stories of how human crimes are punished in hell and how good people become gods and are freed from the cycle of life and death are widely publicized through opera, songs, storybooks, and wall paintings. For example, if

one tells a lie, the tongue will be cut off; a person who commits adultery will be deep fried in a big pot of hot oil; individuals who beat their parents will be sawn in half. The punishments are terrifying, and it is probable that such stories were promoted to affirm social and moral standards and sanctions in society.

Buddhist Views on Death

The dominant Buddhist view is that life and death form a perpetuating cycle; life does not begin at birth, nor does it end at death, as there is rebirth. When a person dies, the physical body returns to nature while the mental energies manifest themselves in another form, either through rebirth or re-becoming. When someone passes away, he or she may suffer in three realms of evil: hell, hungry ghosts, and brute beasts. Therefore, death rituals serve to relieve the dead of these sufferings, as well as to guide the deceased through the journey to rebirth. In order to be reborn into a better place, one must avoid bad deeds and tread the right path in life.

Daoist Views on Death

The fate and salvation of the dead in the netherworld remains a central concern in Daoist funerary services. Death rituals serve to summon the dead soul, to deliver it from suffering in the underworld, and to transform it through the renewal of life. There is a belief that there is an "inheritance of sins" that continues and grows over generations. Evil deeds committed by ancestors are connected with the misery, suffering, and calamities experienced by the current generation. By performing death rituals, the living can help the dead accumulate merit and thus decrease the impact of the dead on the living.

Those who have no family (preferably male descendants) to perform the necessary rites are doomed to become "hungry ghosts," homeless and dangerous who seek victims to kill so they can reincarnate. Thankfully, these spirits are locked up in hell except for 2 weeks of every year beginning on the 14th day of the 7th month of the Chinese lunar calendar. To propitiate these evil ghosts at this time, Chinese operas and public offerings are organized. Rice will be distributed to the poor so that both the living and the dead will be rid of hunger. This Ghost Festival is a major event in traditional Chinese communities.

Understanding Chinese Death Taboos

The Chinese are one of the biggest migrant groups in many major cities in North America, Australasia, and Europe. Mental health professionals and bereavement counselors in those places need to be aware of Chinese attitudes toward death and the associated taboos. The low utilization rates of hospices, palliative care, and bereavement and mental health services may be partly due to the cultural alienation that Chinese people experience when their views are either not understood or not respected. Understanding of these taboos and the creative utilization of Chinese rituals in the design of social and health services are crucial to the Chinese, wherever they may live.

Cecilia Lai Wan Chan

See also Buddhist Beliefs and Traditions; Causes of Death, Contemporary; Daoist Beliefs and Traditions; Reincarnation

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Christian Beliefs and Traditions

Christianity is a monotheistic religion that centers on the life and teachings of Jesus of Nazareth as

they are presented in the New Testament. The New Testament is the second major component of the Christian Bible. The Hebrew Bible, called *Tanakh* in Jewish theology and the Old Testament in Christian theology, comprises the first section of the Christian Bible. Although they may differ in the book order, most Christian denominations define the New Testament as 27 books, which include the four gospels, the book of Acts, the 21 epistles, and the book of Revelation. Some Christian groups, however, challenge this composition by including additional books or excluding one or more of the 27 core texts.

Christianity is the largest religion practiced in the world. Approximately 2.1 billion people identify as Christians. The United States of America, Brazil, and Mexico have the three largest national Christian populations. Christians make up roughly one third of the world's population.

There are five major branches of Christianity—Orthodox, Catholic, Protestant, Anglican, and Restorationism—and over 34,000 Christian denominations. The Roman Catholic Church is the largest church with more than 1 billion participants. Protestants, as a branch of Christianity, comprise the second largest group with approximately 500 million adherents. Although the term *Christian* encompasses diverse religious ideas and practices, this entry highlights the shared beliefs of the crucifixion of Jesus of Nazareth and the role of his death in redemption and salvation. The differences between Protestant, Orthodox, and Catholic interpretations of the consecration of bread and wine during Christian services also are addressed.

Jesus of Nazareth

Christian beliefs center on the life and death of Jesus of Nazareth. Most Christian groups revere Jesus as the son of God and the incarnation of God. For Christians, Jesus is divine. He is the Messiah, or one who is anointed, whose arrival was prophesized in the Tanakh or Old Testament. The word *Christ* is the English term for the Greek word Χριστός (*Khristós*). Kristos was used in the Greek Old Testament to translate the Hebrew-derived word *Messiah*. Christ, which is a title and not a name, describes the divine nature of Jesus of Nazareth. In common usage, Jesus the Christ is generally shortened to Jesus Christ. Followers of Jesus are known as Christians, since they believe that Jesus is the anointed one. According to Christian theology, Jesus died for humanity's sins. His birth, crucifixion, resurrection, and ascension into heaven were required to open the gates of heaven, or salvation, to human beings. Without this sacrifice, people would not be able to join God in eternal life.

The exact date of Jesus's birth is unknown, but scholars commonly estimate that Jesus was born between 6 and 4 B.C.E. The story of his birth is told in the writings of Matthew and Luke in the New Testament. The traditional Christian understanding of Jesus's birth emphasizes that he was conceived by the Holy Spirit and by Mary of Nazareth, who was a virgin at the time of conception. Many Christian groups (including the Roman Catholic Church and the Eastern Orthodox Church) assert that Mary was a virgin during Jesus's conception and for the rest of her life. Other Christian churches (e.g., many Protestant churches) teach that Mary was a virgin during conception, but not for her entire life.

Prior to the conception of Jesus, the angel Gabriel appeared to Mary while she was engaged to Joseph. Gabriel told Mary that she was to be the mother of the Messiah and the child would be conceived by the Holy Spirit. An angel of the Lord also told Joseph about Mary's pregnancy in a dream. The angel told Joseph not to be afraid, to continue with the marriage, and to name the child Jesus. Joseph and Mary married, and Jesus was born in Bethlehem, Judea.

The conception of Jesus is celebrated as the Feast of Annunciation on March 25. The birth of Jesus is commonly celebrated on December 25. Eastern Orthodox Christians, however, celebrate Jesus's birth on the evening of January 6 and the day of January 7, a period known as the feast of Theophany or the feast of Epiphany. Prior to 330 C.E., Roman Christians also used the January date to mark Jesus's arrival.

Beyond his birth, little is known about Jesus's life before he began his public ministry. Jesus started his work as a teacher and healer when he was around 30 years old, and spent approximately 3 years doing this work. According to the gospels, he drew large crowds (at times numbering in the thousands) as he traveled and spoke in Galilee and Perea.

Jesus's final meal with the apostles, the 12 people chosen to spread the word of Jesus's

teachings, before his execution is an important event in Christian traditions. During the meal, which is commonly known as the Last Supper or the Lord's Supper, Jesus explained that one of the apostles would betray him. He also shared bread and wine and told his disciples that these were his body and blood. The gospels of Matthew, Mark, and Luke and the First Epistle to the Corinthians discuss this dimension of the final meal. For example, the Gospel of Matthew (26:26–29) notes: "Now as they were eating, Jesus took bread, and blessed and broke it, and gave it to the disciples and said, 'Take, eat; this is my body.' And he took a cup, and when he had given thanks he gave it to them, saying, 'Drink of it, all of you; for this is my blood of the covenant, which is poured out for many for the forgiveness of sins. I tell you I shall not drink again of this fruit of the vine until that day when I drink it new with you in my Father's kingdom.'"

After the final meal, Jesus prayed in the Garden of Gethsemane. Temple guards arrested Jesus while he was in the garden. Judas Iscariot, one of the apostles, is said to have betrayed Jesus by identifying him to the guards. Jesus of Nazareth was eventually charged with treason and brought before the Roman procurator Pontius Pilate. Pilate offered the crowd a choice between Jesus of Nazareth and Barabbas, a political prisoner charged with insurrection. The crowd opted for the freedom of Barabbas and Jesus was sentenced to death. Jesus died in Calvary (also called Golgatha) after being crucified on a wooden cross.

Death and Resurrection

The books in the New Testament explain how Jesus was crucified, died, and buried within a tomb. Three days after his death, Jesus was raised from the dead. The gospels of Matthew, Mark, and Luke all tell of the resurrection of Jesus. Each text, however, emphasizes different points and varies in the details provided. In the Gospel of Matthew, for example, an angel appeared to Mary Magdalene and another Mary (believed to be Mary the mother of Jesus) when they went to anoint Jesus's body with spices and told them that Jesus would be resurrected. In contrast, the Gospel of Luke says there were two angels, whereas the Gospel of Mark suggests it was a youth dressed in white.

Mary Magdalene, a disciple of Jesus, was the first person to see Jesus after he returned. The Gospel of John details how Mary Magdalene returned to Jesus's tomb only to find his body missing. Weeping at the tomb's entrance, Mary Magdalene did not initially realize that the person near her was Jesus. After recognizing him, Mary Magdalene was told to spread the word of Jesus's resurrection to other disciples.

In the New Testament, Jesus appears multiple times to followers after his death. For example, on one of these occasions, popularly known as the "Doubting Thomas" occasion, Thomas the Apostle encounters Jesus. Thomas does not believe that the person he sees is Jesus and asks to touch the wounds in Jesus's hands and feet to verify his identity. For Thomas, seeing is not believing. Touch is needed to affirm Jesus's resurrection.

Ascension

Although multiple versions of the Ascension exist, accounts emphasize how Jesus bodily ascended into heaven 40 days after resurrection. After ascending to heaven, Jesus sits at the right hand of God, comprising part of the holy Trinity. The Trinity doctrine states there is one God, who is Father, Son, and Holy Spirit. The bodily ascension of Jesus represents the union of human beings and God. It highlights how Jesus embodies both the divine and the human. The Ascension is discussed in Mark 16:19, Luke 24:51, and in the first chapter of the Acts of the Apostles. The Apostle's Creed and the Nicene Creed also celebrate this event.

Historical Sites

The historical sites associated with the crucifixion, burial, and ascension of Jesus are located in Jerusalem. The Church of the Holy Sepulchre, also known as the Church of Resurrection, is believed to be the site where Jesus was crucified and buried. The hill of Calgary, the site of crucifixion, and the tomb where Jesus was buried are both believed to be located at this site. Roman Catholics, Greek Orthodox, Armenian Orthodox, Syrian Orthodox, Coptic Orthodox, and Ethiopian Orthodox all share in the control and management of The Church of the Holy Sepulchre, which is located within the walled Old City of Jerusalem.

The Chapel of Ascension (also called Mosque of the Ascension, Church of the Ascension) in the Village of al-Tur, Mount of Olives, Jerusalem, is believed to mark the site where Jesus ascended into heaven. A stone imprinted with Jesus's footprints is displayed in the chapel/mosque. The Islamic Waqf of Jerusalem owns the site, which is open to the public. The area has been a sacred spot for thousands of years. Early Christians initially honored the Ascension of Christ in a cave on the Mount of Olives. By the late 300s C.E., the site of the Ascension was established at the present location, uphill from the cave.

Holy Communion, the Eucharist, and Transubstantiation

Christians remember Jesus's actions at the final meal with disciples in weekly services through the act of Holy Communion, or the Eucharist. The word *Eucharist* can refer to the act itself and/or to the bread and wine used during the act. During Holy Communion, the priest or minister blesses bread and wine (or grape juice) through a series of prayers and actions. After the bread and wine are consecrated, churchgoers leave their seats and go to the front of the church to receive a piece of bread and a sip of wine (or grape juice). This ritual re-creates the moment during the final meal when Jesus gave disciples bread and wine, explaining that these were his body and blood. It reminds Christians of how Jesus "poured out his blood" during crucifixion so that people could be restored to grace.

Most Christians believe that communion brings a person in relation to the presence of Jesus in some way. Christians differ, however, in how they understand what occurs during this rite. Roman Catholics, Orthodox groups, and some Anglicans, for example, believe that the bread and wine are turned into the actual body and blood of Jesus. The Roman Catholics have developed a theory of transubstantiation to explain this transformation.Transubstantiation is the transformation of the bread and wine into the actual body and blood of Jesus by the Holy Spirit. Although they continue to look like bread and wine, the Holy Spirit changes the substance of these objects into the body and blood of Jesus. This ritual symbolizes the separation of Jesus's body from his blood on the hill of Calvary and their reunion during resurrection. Within Roman Catholicism, only ordained priests can consecrate the bread and wine for Holy Communion.

Commemorating the Crucifixion, Resurrection, and Ascension of Jesus

Beyond the weekly commemoration of Jesus's sacrifice for humanity in Holy Communion, specific holy days mark Jesus's death, resurrection, and ascension. These holy days are not fixed in relation to secular calendars, but are considered "movable feasts." That is, they are determined in relation to the moon cycle (not the cycle of the sun), and the actual dates of each change from year to year. Each holy day is marked by a church service as well as other activities.

Lent is the period of fasting and prayer that precedes the celebration of Jesus's resurrection. Lent generally lasts for 40 days, but there is a variety of ways churches calculate this liturgical season. Lent evokes the 40 days Jesus spent in the desert, where he fasted and was tempted by the devil. It is a somber time—one in which adherents turn inward for reflection and give up particular foods and festivities. In contemporary times, some Christians give up vices such as cigarette smoking or gambling during Lent.

Holy Thursday and Good Friday mark the final days of Lent. Christians recall the last meal Jesus shared with his disciples on Holy Thursday. Good Friday, the day following Holy Thursday, honors Jesus's crucifixion and burial. It is a solemn day and Christians are expected to be sober and quiet. The Christian season of Lent ends on Easter Vigil at sundown or at sunrise on Easter Sunday, depending on the denomination.

Easter is a joyous occasion—one that celebrates the resurrection of Jesus from the dead. For most Christians, Easter occurs between late March and late April each year. Easter is the first Sunday after the paschal full moon, which is the first moon whose 14th day is on or after the vernal equinox, March 21. Easter is one of the best-attended Christian holy days. Both Christmas and Easter draw large numbers of participants to services.

Many Christians incorporate pre-Christian beliefs and symbols into the celebration of Easter. For example, some Christians celebrate Easter by sharing decorated eggs. As part of Easter, eggs

represent the resurrection of Jesus and the promise of new life. Yet, eggs are also an ancient symbol of fertility. Within Judaism, the Passover Seder meal uses a hard-boiled egg to evoke sacrifice and the continuation of life. The Easter bunny is thought to refer to the hare, which also was an ancient symbol of fertility. The name Easter itself comes from Eostre, the pre-Christian Saxon goddess of fertility and birth. First-century pagans worshipped Eostre and thought she could bring fertility to families and crops. The celebration of Eostre was near the celebration of Jesus's resurrection; thus, missionaries adopted the name Easter to gain converts.

The Ascension of Jesus is celebrated on Ascension Day, which is held 40 days after Easter Sunday and usually falls on a Thursday. Some denominations, however, celebrate Ascension Day on other days. Although Ascension Day is important to Christians, it does not get the turnout associated with Easter.

In all, Christian beliefs and traditions are diverse and varied. Nevertheless, across denominations Christians share a belief in the importance of Jesus's crucifixion, resurrection, and ascension as the cornerstone of their faith. This significance is reflected in the designation and observation of holy days that commemorate these events. For Christians, Jesus's death and resurrection allow the salvation of humanity. Without his death and rebirth, human beings would not be reconciled with God and would be unable to enter heaven or eternal life after death.

Kelly A. Joyce

See also Angels; Apocalypse; Armageddon; Heaven; Hell; Last Judgment, The

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Chronic Sorrow

Chronic sorrow refers to frequently misunderstood, unrecognized, pervasive, continuing, and resurgent grief responses that result from coping with loss due to significant permanent injury, illness, disability, or progressive deterioration of oneself (self-loss) or another living person (other-loss) to whom there is a deep attachment. As the source of the loss is ongoing, grief responses are usually life-long. The experiential core of this type of grieving is a painful disparity between perceptual reality and thoughts of what might have been, should have been, and still may be hoped for.

Chronic sorrow is frequently inaugurated by trauma, whether it is momentous (e.g., paralysis due to spinal cord injury; birth of a child with previously undetected, obvious anomalies), or consists of gradual, incremental concerns that culminate in a realization of the loss or its true severity (e.g., symptoms being confirmed as multiple sclerosis, worsening condition being diagnosed as schizophrenia). Recognition that life as it has been and was expected to be is forever lost and has been replaced by an initially unwanted, unknown, and often terrifying new reality can be considered a psychological emergency. The onset of chronic sorrow forces a reappraisal of one's assumptive world, that is, the very beliefs in life's predictability and fairness that have defined one's existence. Hence, the self and the world must be relearned, an arduous but potentially beneficial process that is often a focus of concern throughout the life span. In many instances there is a need for constant vigilance, around-the-clock care, expected and unexpected crisis management, and other severe and relentless reality demands.

Chronic sorrow per se is normal, and its manifestations are of interest to many professional human service disciplines, including thanatology, social work, nursing, psychology, psychiatry, family therapy, education, law, religion, rehabilitation,

and medicine. It is likely that the prevalence of chronic sorrow is increasing. Many persons with congenital disabilities once thought to signify limited and precarious lives are achieving normal longevity. As a result of technological improvements in health care, life spans of low birthweight infants and persons with many severely disabling conditions are lengthening. Survival rates for stroke victims and persons with major head trauma are increasing. Casualties of war, atrocities, and protracted, large-group conflicts add to this toll.

Conceptual Development

Introduced in the 1960s by Simon Olshansky, a rehabilitation counselor, administrator, and researcher, the concept of chronic sorrow was based on observations of parents of children with developmental impairments. Its applications and intent were clearly articulated, recasting what had been considered pathological as normal. Introduction of this concept heralded a paradigm shift by challenging prevailing professional perceptions, including stereotyping, negative labeling, and pathologizing of parents who were often seen as neurotic, autistogenic, schizophrenogenic, overprotective, and never satisfied. Although functioning devotedly with a paucity of resources to help their children, parents were caught in the currents of pervasive and episodic grief due to losses that were living, ongoing, largely disenfranchised, and that do not lend themselves to resolution or integration in the same way that many losses with finality do.

Following the introduction of the chronic sorrow concept, research activity was intense in validating the concept and assessing some of its aspects. Professional interest, as measured by the number of publications on chronic sorrow, declined somewhat in the 1980s. In the early 1990s, however, a renewed interest occurred, most notably in the field of nursing. The Nursing Consortium for Research on Chronic Sorrow (NCRCS) was established by the faculty of several nursing schools. Through their efforts, a number of important empirical research studies have been conducted with NCRCS support and oversight. An increasing interest in chronic sorrow by other professions as well has led to the recent development of specialized research tools, such as inventories, questionnaires, and scales.

Beginning in the 1990s, the concept of chronic sorrow has been undergoing an expansion from its original application to other ongoing loss situations. It is now considered applicable and useful to the understanding of the effects of a wide range of chronic diseases, disabilities, and progressive mental and physical deterioration such as spina bifida, amyotrophic lateral sclerosis (ALS), multiple sclerosis, Parkinson's disease, chronic mental illness, AIDS, Alzheimer's disease, and protracted coma, among others. The concept has been validated in many of these conditions, both for large numbers of those who are themselves the locus of the loss (self-loss), and for those who love them and care for them (other-loss). Because it pertains to ongoing and living losses, chronic sorrow may also apply to a limited number of other situations as well, such as many mothers who have relinquished their babies for adoption and are unable to determine what happened to them. Many such women report pervasive and resurgent grief responses, some more than 20 or 30 years following relinquishment. Chronic sorrow is also suggested as a useful construct in understanding and ameliorating the experiences of refugees and immigrants who have lost their culture, their country, the language of their birth, and intimacies of friends and family members left behind. The concept may also apply to some cases of infertility, as well as to loved ones of persons who have vanished; for example, those missing in action (MIAs), kidnap victims, and those who have inexplicably disappeared, their fates unknown.

Salient Characteristics of Chronic Sorrow

The existence of chronic sorrow is a function of how the loss is interpreted. Cultural context, group affiliations, and other spheres of influence affect the perception and meaning of loss. Individual factors influencing interpretations and responses include (a) identity development and self-appraisal, (b) lifestyle and circumstances, (c) history of losses, (d) spiritual beliefs and philosophy, (e) dreams and expectations, (f) quality of support, (g) degree of stigma, and (h) temporality within the life span. It may take many years for the full extent of the loss to be realized and accommodated. Moreover, interpretations may vary over the course of a lifetime for the same individual.

Understandably, there are qualitative experiential differences in how chronic sorrow is experienced by persons who are the locus of the loss as compared to those who are emotionally close to them (e.g., parents, siblings, partners, devoted friends). In some situations, self- and other-loss are reciprocal and interactive, for example, some caregiver–care receiver relationships.

Fantasy

The central role of the fantasy of what should or could have been and what continues to be hoped for is extremely complex and persistent, and its effects are both positive and negative. The fantasy can provide hope, forestall depression, and energize efforts to obtain the best possible resources, especially during the initial months and years after the onset. Activation of the fantasy can also intensify painful emotions due to the marked discrepancy between lost expectations and current living reality. With the passage of time, a gradual diminution of the fantasy and its potency, while attaching hope to more realistic possibilities, is usually beneficial, as chronic sorrow is fraught with unavoidable reminders of the loss, as well as external and internal triggers that can ignite sudden, temporary resurgences of grief intensity. Predictable stress points are well documented and are related to time periods during which developmental milestones and life cycle transitions would occur but cannot be obtained due to the severely limiting aspects of many chronic sorrow situations. Special events such as birthdays, Mother's Day, Christmas, and anniversaries can also trigger an increase in grief intensity.

Due to the lack of normative developmental and transitional markers, time may not have the same relevance as a means of ordering life events in the memory and retrieval systems of those affected by chronic sorrow. Because life narratives may not be formatted in the same way they are for unaffected cohorts, recall for personal history may be less distinct. Narratives may be sketchier, less sequential, more disorganized, and reflective of a life that is marker bereft. Moreover, when clear markers do exist, they may be negative.

Disenfranchisement

Chronic sorrow is frequently characterized by disenfranchisement. Often there is little or no social recognition that a loss has occurred, and there may be only scant social recognition of the person who is the source of the loss. There are no socially sanctioned ways in which to grieve the loss and no customary rituals or other systemic resources that provide support for grieving. At the time of realization of the loss, those most directly affected may be destabilized. It is normal for chaotic circumstances to last for a year or even longer. Despite these crisis conditions, the majority of affected persons are able to meet their challenges and function capably. Over the life span, however, shifting reality demands, chronic and episodic stress, and other effects of chronic sorrow usually preclude permanent adaptations. Despite its ongoing nature, chronic sorrow is *not* a state of permanent despair. The development of tenacity, resolve, a deeper sense of meaning and purpose for one's life, and other transformative processes can and usually do occur.

Complications and Family Impact

While chronic sorrow per se is nonpathological, it can increase susceptibility to complications over the life span. These include (a) clinical depression, (b) problems with identity development and poor self-esteem, (c) guilt, (d) anger, (e) stress (chronic and episodic) and stress-related ailments, (f) anxiety and clinical or subclinical trauma symptoms, (g) a deep sense of loneliness and alienation, (h) disordered intimacy and attachment (e.g., enmeshment, prohibitive fears of closeness or of having wants and desires), (i) existential angst (e.g., disillusionment and spiritual conflicts), (j) addictions relapse, and (k) periodic affective flooding or loss spirals that may be so overwhelming as to be temporarily disabling.

Even in contemporary diversified family structures, family identity and social ostracism are powerful forces in the lives of family members. Family stress is amplified when developmental transitions are not completed by a member who cannot achieve independence. Loss of privacy occurs due to the involvement of health service providers. Many services are provided in the home, and the effects of this necessary intrusion into family life hold consequences for all family members. Effects of chronic sorrow conditions on children in the household vary widely. Some feel resentful of being deprived of their parents' attention. Some

are affected by survivor guilt. Some children become precociously intuitive, compassionate, and wise. Effects on the marital relationship also vary. Some relationships are splintered, while others are strengthened. The problem of depleted caregivers is often unavoidable. Most families regain resilience and organization, and many families report improved cohesion, hardiness, and increased compassion, gentleness, and understanding among family members. Family functioning is generally enhanced by structure, predictability, role flexibility, and by acknowledging and balancing the needs of all family members in some equitable way.

Chronic sorrow can give life its purpose and meaning. It may also be characterized as a series of losses that accrue throughout the life span. As it can and often does become the lens through which all else is viewed, it may play an invisible role in end-of-life decision making. Recognition and understanding of chronic sorrow by all health service providers can only be of benefit.

Susan Roos

See also Acute and Chronic Diseases; Ambiguous Loss and Unresolved Grief; Caregiver Stress; Disenfranchised Grief

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Clergy

Clergy is a commonly used term to describe spiritual leaders within a faith community who serve a local assembly of adherents such as a congregation, synagogue, or mosque, or provide spiritual care in a specialized setting such as a hospice, university campus, or military unit. As leaders in their faith communities, clergy have a historic and enduring presence during times of dying, death, and bereavement. Although the role of clergy varies between and within religious organizations, there is continuity in the important role that the clergy provide in assisting the dying, interpreting religious laws governing death, performing burial rites, and consoling the grieving.

The Greek word from which *clergy* is derived has roots in the Judeo-Christian theological idea that it is the *lot* or the *inheritance* of the clergy to serve God in ritual worship on behalf of the community. Most theistic traditions understand the clergy to have a divine calling that destined them for this work and ordain individuals in some ritualized ceremony for this function of leadership within the faith community and representation of it to the outside. Other terms for clergy are faith-group specific, such as *priest* (Anglican, Buddhist, Orthodox, Roman); *minister*, *pastor*, or *elder* (Protestant); *rabbi* (Jewish); imam or *mullah* (Islam); *medicine man* (Native American); and the like. Faith traditions also dictate whether the clergy role is open to both men and women or is restricted to one gender, as in the Roman Catholic practice of restricting ordination to males.

Professional Preparation

Most clergy undergo a rigorous course of undergraduate and graduate studies in preparation for clergy leadership roles. The Association for Theological Schools is recognized by the U.S. Secretary of Education and the Council for Higher Education Accreditation to set academic standards for the more than 250 accredited graduate

schools that offer postbaccalaureate theological programs. The standard Master of Divinity (M. Div.) degree required by most faith groups for clergy ordination involves a minimum of 3 years of full-time academic work to meet the educational and personal spiritual formation criteria. Many seminaries include clinical pastoral education as a degree requirement; this education involves students working directly with people in spiritual need, such as hospitalized patients, while being observed in their ability to understand and relate effectively. This direct supervision assists in the development of spiritual assessment and interpersonal skills that are crucial in clergy pastoral work, such as ministry to the dying or bereaved.

Respected Leaders

Despite recent exposure of clergy sexual abuse, clergy are still recognized as esteemed leaders in their communities. A 2007 career survey in *U.S. News & World Report* included clergy as a respected profession, noting that religion provides an anchor in the lives of millions of Americans for which the clergy are regarded as indispensable religious leaders.

The U.S. Department of Labor, Bureau of Labor Statistics for the year 2006 reports there are over 404,000 active clergy in the United States. However, the actual number of clergy is likely much higher since the Department of Labor reports only salaried professionals, whereas clergy may serve in a on stipendiary arrangement, providing clergy services without remuneration or in exchange for other benefits such as clerical housing. Moreover, many nontraditional and new age religious communities may also fall outside of government reporting systems. The 1996 edition of the *Encyclopedia of American Religions* contains over 2,600 entries on religious bodies, suggesting the continued prevalence in U.S. society of numerous religious institutions along with their clergy leadership.

From Cradle to Grave

As faith community leaders, clergy regularly conduct worship services, preach, administrate, teach, counsel, and provide spiritual support. At times of significant life cycle passages, such as birth, coming of age, or marriage, clergy offer religious instruction and ceremony to mark these symbolic passages. Thus clergy offer premarital counseling sessions to prepare couples for marriage and conduct wedding ceremonies, they incorporate newborns into the faith community through sacramental rites (such as baptism into the Christian faith), and they preside at coming-of-age rituals such as a bar or bat mitzvah in the Jewish tradition.

But it is particularly during times of dying, death, and bereavement that clergy play a most significant role. Often viewed as an icon of hope in the midst of loss, the clergy serve as a familiar and supportive figure to individuals, families, and the wider community as they attempt to cope with the finality of death. It has been said that at the kingdom of the bedside, the pastoral shepherd is a nobleman. Because many religions espouse an afterlife, clergy are also sought for their wisdom, consolation, and insight into the sacredness of dying and the profound transition it marks between this life and what is understood to follow.

Pastoral Care Role and Functions

The role of clergy in all faith groups is to embody the resources, wisdom, and authority of the tradition's teachings and to apply them to the different life circumstances of the members. This practical application, or pastoral care, includes the personal attention the clergy offer to those needing emotional and spiritual support. A historical survey published in 1964 delineated four classic functions of pastoral care provided over the centuries as traced in key writings of pastoral leaders. These involve pastoral activities of healing, sustaining, guiding, and reconciling. These functions have broad application even beyond the Christian tradition because they pertain to common ways clergy of all faith traditions interact with persons in need. When applied to the clergy role in circumstances of dying, death, and bereavement, these four activities provide an understanding of the important pastoral care contribution clergy make.

Healing Role

Healing involves a restoration to wholeness, understood within a religious context as an inner spiritual state rather than solely the absence of disease or the search for a cure. While prayer for

cure is not unknown, clergy also pray for and with the terminally ill, anoint them in ceremonial acts to strengthen their inner sense of wholeness, and join families in prayers of commendation for the dying when death approaches. When cure is not a plausible goal, there is much spiritual strength to be gained with an enhanced sense of wholeness that is linked to communion with the divine as well as to family and personal relationships that are restored to wholeness.

Thus in many of the Christian traditions, anointing of the sick by the clergy with blessed oil is intended to convey both physical and spiritual healing during times of serious or life-threatening illness. Clergy perform this healing sacramental ritual at the bedside with the patient alone or including family and significant others. Over time, this ritual became so associated with the event of death that it was referred to as "last rites" and misperceived as essential to assure the safe transition to the afterlife. However, clergy increasingly use the anointing prayers at earlier stages of serious illness to express the support of the faith community for spiritual well-being in the midst of illness, as well as prayer for physical healing. When death is inevitable, however, anointing also serves to assure all of a broader sense of healing through the wholeness of spiritual peace.

Sustaining Care

Sustaining acts of pastoral care seek to support troubled persons in the vicissitudes of life. Pastoral sustaining includes encouragement to persevere in the face of death's power to otherwise cause fear and hopelessness, to gain strength by drawing from religious resources such as spiritual readings or devotions, and to experience comfort by the awareness of a faith community that prays for and with those coping with loss and grief. The pastoral act of sustaining also helps to restore a sense of the future and the importance of ongoing life.

For example, an imam sustains grieving survivors after a death by leading them in the proper Muslim practices for burial of the body. This involves arrangements to meet the religious requirement for burial, within 24 hours of the death, in a dedicated Muslim cemetery. At graveside, the imam may lead the ceremony, which includes the proclamation of the *Allahu Akbar* ("God is great") four times, reading Al-Fatihah, Sura 1, recitation of praises to the Prophet, prayers for the deceased, and prayers for the mourners. These ritual observances officiated by the imam uphold the grieving family by assuring them that they have fulfilled their religious obligations to the deceased with proper burial. The imam may also involve other members of the mosque to surround the grievers with understanding, creating a wider sense of validation of the significance of the loss. This support helps to sustain grievers as they move toward the future without the loved one who died.

Guiding Function

The guiding function of clergy care is focused on drawing upon a faith tradition's wisdom as it illuminates problem solving and decision making that align with the tradition's values and teachings. Clergy guidance can range from a casuistry system, in which a body of religious principles and rules are applied, to a specific situation to determine a decision to a supportive system in which a pastoral relationship of listening, understanding, and reflecting is offered from which emerges thoughtful but personal decision making.

For instance, in Jewish care of the dying, the rabbi may offer specific religious guidance about how the dying process is to be approached. A rabbi will look to the *mitzvot,* understood to be the divinely given commandments, to guide decisions about the preservation of life even as death approaches. There is some variance within Jewish religious traditions, but typically the rabbi will uphold the sanctity of God-given life by opposing any hastening of death such as in acts of euthanasia. Instead, the rabbi may guide the patient and family to a hospice that can provide end-of-life care designed to relieve the suffering of the dying and provide emotional and spiritual support to the entire family.

At others times the guiding function is expressed in the clergy's readiness to teach and discuss the understanding of the ultimate meaning and purpose of life in light of death. The approach of death can both deepen and stress the explanations that a religious tradition offers to its adherents. Clergy guide the dying or the bereaved to more completely understand their religious faiths' teachings regarding the human experience of death. Thus, Buddhist clergy will offer the Buddha's teaching

about the impermanence of life, the importance of calm and enlightened consciousness at the moment of death, and the insight that ultimately death is a friend since it leads to new realms of existence through accumulated karma. Through this guiding function, clergy of all traditions enable those under their care to transcend the pain of loss and experience solace in continuity with all those who, over time, have similarly experienced loss in death.

Reconciling Activities

The reconciling function pertains to those clergy activities that assist alienated persons to reestablish broken bonds with the divine as well as to mend estranged relationships within the family or circle of loved ones. Human reconciliation to the divine, in many religious traditions, requires an accounting of past behavior in the form of confession. Confession can be made privately to the clergy or corporately in the assembly of the faith community. An intention to rectify wrongdoing may also be required, such as the expression of regret and an intention to change before forgiveness and reconciliation are fully embraced.

Clergy efforts to foster reconciliation can be especially poignant in the context of dying since future time is obviously limited. Yet, the fact of restricted time can be an impetus for a dying person to focus on the accomplishments and regrets of a life. Some have suggested that the period of dying is a particularly fruitful time for relationship completion, especially if there is "unfinished business" among loved ones. Clergy are in a unique position to facilitate discussion on topics such as forgiveness, gratefulness, and love to foster a more complete and peaceful good-bye. Research suggests that such emotional and spiritual closure will also contribute to better outcomes in the bereavement period that follows a death.

For a time during the 20th century, advances in Western medical technology seemed to have displaced clergy from their traditional roles in spiritual support of the dying and the bereaved. Dying had become a medical challenge to be conquered, rather than an expectable though painful experience within the cycle of life. However, the death awareness movement of the last half of that century seems now to have restored a more holistic understanding of all aspects of dying, death, and bereavement, including the importance of spiritual understanding and the role of clergy as teachers, guides, and comforters to the dying and bereaved.

Paul Metzler

See also Christian Beliefs and Traditions; Funerals; Grief and Bereavement Counseling; Hindu Beliefs and Traditions; Jewish Beliefs and Traditions; Muslim Beliefs and Traditions

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Cloning

The concept *cloning* refers to artificial embryo twinning, somatic cell nuclear transfer, and removing stem cells from embryos and adult individuals to be used to "grow" tissues, organs, or individuals. Embryonic cloning involves using an electric current or other technique to split a preembryo into two, each of which has the potential, under optimal circumstances, of gestation and parturition to develop into a member of the species. The more powerful technique of somatic cell nuclear transfer involves the removal of the nucleus of an unfertilized ovum and replacing it with the nucleus of a somatic cell, such as a skin cell, and then using a small electric current to cause these combined elements to reverse the specialization and revert to stem cell status. The resultant cell is somewhat like a fertilized ovum, except that the bulk of its DNA is that of the donor organism with the exception of the mitochondrial DNA that comes from the ovum. Finally, one goal of human therapeutic cloning is to produce cells that are

progenitors of those for specific organs, not entire organisms. Such cloning is commonly referred to as therapeutic cloning: the cloning of organs and tissues that are histocompatible with a potential recipient of a transplantation of the resultant cells or organ. To date, cloning as a technique is in its infancy. Medical science has little interest in cloning individuals or in artificial twinning. The major thrust is toward human therapeutic cloning.

Cloning and Death

The prospect of death, whether of oneself or a loved one, frightens most humans. The fear may involve various dreadful prospects supposed to await the dying person, from hell's fires, to the pain of separation, to the experience of nothingness. Even those not burdened by belief in an afterlife of judgment seek to remain alive as long as life holds a positive balance of meaningful activity.

Humans have long sought to extend life and forestall death by imprecations, pharmacological supplementation of essential physiological chemicals, surgical removal of tumors, and repair of injuries. In pursuit of longevity humans will cut calories to close to a starvation regimen, ingest unproven and disproven drugs (like laetrile), employ useless procedures (like coffee enemas), and take combinations of substances (like mega-vitamin therapy) believed through a combination of anecdote, assurances, and gullibility to beat back cancers and other life-threatening conditions. More recently, replacement of organs with transplants from donors, living and dead, human and animal, have become the more scientific tools of life extension. Modern medicine and its alternative imitators have become the first and last hope of the sick and dying.

The relatively recent emergence of human reproductive cloning techniques has added several other stratagems to the tempting arsenal of weapons against imminent death. This entry discusses the present technology of human reproductive cloning and the possibilities of human therapeutic cloning for replacement of lost or injured parts and for replication of highly valued individuals.

Cloning and Immortality

Some individuals view cloning as a kind of immortality. But such views are not consistent with the facts. A clone is a much younger twin of the cloned individual. Just as, when a twin dies, it is not claimed that he or she somehow lives on in the survivor, so it wouldn't be said of a clone that he or she is "the spittin' image," or exact duplicate or replica, of the source of the cloned DNA. The reason is that a clone would be raised by different parents in a different time with different influences on its development. Identity has as much to do with the specifics of time and place as it does with genetic endowment.

Clones as Organ Farms

However, there are other attractions to having a clone twin. A clone would be a potential source of transplantable organs for an individual who suffers from severe vital organ failure. And the transplantable heart or liver or kidney would not require suppression of the immune system, as it likely would be recognized as "same" by the individual's defenses against foreign protein. Transplanted organs from cadavers or neomorts are typically histologically incompatible with the recipients, necessitating a life-long regimen of drugs to suppress the immune system.

The problem with this "solution" to the need for transplantable organs is that, to date, the ability to clone humans as "organ farms" is highly constrained by both ethical and practical considerations. Ethically, of course, creating another human individual to serve as a potential source of organs is a monstrous idea that violates the most fundamental canons of morality. Such clones, created specifically to provide older twin siblings with a pool of compatible organs, would return the world to a kind of exploitative slavery the equivalent of enslavement practices of the past. Their lives would be forfeited at any time a vital organ was needed by the older twin, and their lives would be otherwise inconvenienced by the need for nonvital organ, tissue, and blood transplants and transfusions. Even if the usual protections of informed consent were scrupulously applied, the clone would be under constant pressure to view him- or herself as in thrall to another, more favored person.

But ethical scruples are not the only reasons not to move toward human cloning for transplantation's sake. As was learned from the unfortunate cloned sheep, Dolly, whose life span was half that

of an ordinary sheep, cloning from adult cells (e.g., skin cells), in the rare case where the effort works, produces an individual already physiologically much older than an infant normally conceived. The apparent reason is that cells from a mature individual have begun to accumulate genetic errors caused by exposure to radiation and other environmental elements, and such breakage serves as a precursor to all manner of disorders, including cancers. To put the point colloquially, the clone created from the DNA of a mature human's somatic cells is born already aged with a biological age roughly equivalent to that of the source of the DNA.

It might be possible to clone an infant and then freeze the embryonic clone to be thawed and gestated upon the need for organ replacement arising in the older "twin." Such a procedure, however, is in conflict with the ethical principle of respect for individuals that serves as a barrier to any such stratagem.

One other theoretical possibility would be to manipulate an embryonic clone, if we had the understanding of development sufficient to do it, to produce only a specific organ for transplantation. In such an approach, the normal embryonic development that is directed by the embryo's DNA in utero would be managed so as to produce only the desired organ. Just how this could be accomplished in utero is unclear and unknown, but it might be possible to "grow" vital organs and other tissues in vitro until mature enough for transplantation. If the clone had been "begun" while the "older twin" was still in infancy, then cryopreserved until it was evident that a vital organ would be needed and subjected to a still-nonexistent methodology of developmental management, such a fantastic possibility might be realizable. But we are far from such therapeutic cloning. More likely is therapeutic cloning of important tissues in vivo, where the normal processes of cell regeneration are managed so as to replace damaged or diseased cells and organs.

Cloning as a Way of Regaining the Individual

Cloning has already been used as a way of "recovering" beloved pets. For individuals with extraordinary disposable income, the cloning of a pet from the cells of a deceased animal offers the illusion of a numerically identical replacement. Apart from such expensive sentimentality, cloning of valuable animal stock, such as a prize bull or racehorse, may be attractive to those who view such animals as utilitarian investments.

Those who have lost children may find the possibility of cloning "replacements" to be powerfully attractive. A parent who has lavished love and nurture on the developing child, only to see him or her struck down by an accident or assailant, might well find the possibility of "starting over" on "that child" to be deeply compelling. One individual who struggled with this possibility is Thomas Murray, President of the Hastings Center for Society, Ethics, and the Life Sciences, whose daughter was murdered in college. In a moving essay Murray reviews the temptation to seek a replacement through cloning his daughter and rejects it as providing a false hope, the illusion of a replica where, because of the unique nature of the lost person and her relationship with others, no replica is possible. He concludes of his lost daughter that it would be preferable to keep the memory of his daughter alive than attempt to produce a genetic facsimile.

Another philosopher, James Lindemann Nelson, has observed that the life of a clone would be inescapably linked to the set of expectations and potentials of the one who has been cloned, so that his or her life would lack the joyous spontaneity that comes with forging one's own identity. While serving as a replacement for one tragically lost might console those grieving that loss, the expectations placed on such a clone would constitute a burden that is both unfair and tinged with pretense.

A straightforward utilitarian reason for cloning individuals would be to recover the talents that particularly gifted persons may have. Many assume Albert Einstein was unique in his genius. Luciano Pavarotti thrilled millions with his stunning arias. Salvador Dali astounds with his inventive genius expressed in depictions of the familiar rendered unfamiliar. Some think these geniuses should be recaptured for posterity.

Apart from the psychological problems, replacement cloning is likely destined to disappoint. Not only are there problems associating with aging DNA, but the influences and conditions that surrounded the cloned individual will differ from those that obtain for the clone. In addition to this immutable fact, present and envisioned technology cannot overcome the dismal morbidity rate of

cloned offspring that plague virtually all cloning efforts for animals.

The benefits of cloning we are likely to see in our lifetime are modest but important. We will come to integrate into medicine's practice the cloning and transplantation of specific tissues and structures as replacements for diseased or damaged ones, enabling lives of normalcy to be realized for those who today struggle with chronic diseases such as diabetes. But regeneration of entire individuals is both improbable and quite possibly a nightmare masquerading as a dream. Cloning, like other life-extending measures, may enable the living to enjoy better lives: For those who have lost loved ones tragically, they will continue to live with their sorrow.

Richard T. Hull

See also Death Anxiety; Life Support Systems and Life-Extending Technologies; Organ and Tissue Donation and Transplantation; Transcending Death

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Clothing and Fashion, Death-Related

Recommended burial clothing for men and women represent an optional purchase for families when making arrangements for the deceased through funeral homes. Other than the *tahrihim* (white linen shrouds symbolic of equality that are traditional among Jews), the *tallit* (prayer shawls), and popular angel wraps and gown sets prepared for infants, contemporary burial garments do not differ from day-to-day clothing; indeed, any type clothing provided by the family is deemed to be acceptable. However, some traditions continue. This entry is based on one such custom of preparing clothes for one's burial that continues among older women of Croatia and Bosnia and Herzegovina, who have prepared their clothes for death and then set these items aside either at home or in the possession of relatives for their future burial. Although the custom has a long legacy in this eastern region of Europe, it is becoming less known among the younger population and, as a tradition and as a fashion, is dying out.

This entry emerges from a visual art project of women in Croatia and Bosnia and Herzegovina who prepare clothes in which they want to be buried. The relationship of those women to death is explored, and the role clothing plays in the social, cultural, and gendered constructions of identity is useful for understanding the women's lives, which have been shaped by turbulent historical, political, and cultural events. Even though men do prepare their clothes for death, it is the case that women have predominantly prepared the clothing for death for themselves and their husbands.

Religion

The influence on the custom of preparing clothes for death developed from different orientations, some of which emerge from the great monotheistic religions that had a strong influence on folk beliefs and customs pertaining to death. These beliefs and customs include different elements of old Slavic cultural heritage, pagan traditions of paleo-Balcan, Asiatic, Greek, and Roman cultures.

The Croatian death and funerary customs are replete with beliefs about another life after death. Such beliefs have theistic roots and are, in large part, inspired by the Bible. These are beliefs in hell, heaven, saints and angels, God, and God's justice and punishments. Connected to these beliefs are ethical questions of good and evil and the belief

that good will be rewarded after one's death, whereas evil will be punished.

The tradition of preparing clothes for death continues to be practiced predominantly in the region's Orthodox Christian and Roman Catholic communities.

However, the custom appears to be less practiced among Muslims because, according to Islamic burial custom, a dead person's body is wrapped in white sheets in the belief that everyone is equal in death. Before the Bosnian war (1992–1995) Muslim women may have prepared their death attire, but now preparation is conducted primarily in the mosques where the death bathing ceremony also takes place.

Clothes for Death: Cultural and Fashion Influences

In a catalogue for the exhibition on funerary customs that was held at the Ethnographic Museum in Zagreb, Croatia, in 1985, it is noted that the preparation of clothes for death represents a rural custom of older people creating the clothes in which they want to be buried. They might also prepare a cover for a coffin and a piece of cloth for tying under the chin and for the hands and legs. Many individuals prepare the best suit or outfit they own or a folk outfit or clothes they wore at their wedding.

Most women fashion their death garments to include a skirt, blouse or a shirt, jacket (as part of the suit), knickers, petticoats, socks, and scarves. In most cases the clothing is brand new, never before worn. Such clothing is special but not too festive.

Some women have more traditional handmade garments, while some outfits are more modern, but for the most part, the outfits are made up of a mix of traditional and modern.

Rosa (see Rosa image) had a waistcoat woven by specially trained tailors for the folk outfits. In the past many people were buried in traditional folk outfits, or wedding dresses; this means that many of the traditional handicrafts are no longer available for display in cultural settings.

Apart from clothing some women had prepared other objects or garments to make their death attire complete. In Croatia women prepare special shawls referred to simply as "towels." Most of these were made from silk or cotton. They were predominantly plain in color, mostly white with few embroidered patterns, although some women

Rosa (Banjica, Bosnia and Herzegovina), 2007

Source: Margareta Kern.

had elaborate embroideries of flowers (see Liza image). The towels are used as decoration during the funeral procession and are usually placed on a cross, carried by the person walking at the front of the procession. After the funeral, some of the towels will be returned to the family to be retained and then used again for many generations, while some towels will be donated to the church. Other, more ordinary cotton towels are used for bathing the person's body after he or she dies.

In Bosnia and Herzegovina some women weave colorful woolen kilims to be placed in the coffin upon which the body is laid. Red thread referred to as "rujak" is commonly used in the death attire in Bosnia and Herzegovina. The threads have more of a symbolic use—once the deceased person's body is laid in the coffin, then a cross is "drawn" with the red thread. In some cases the red thread can be drawn across the hands and across the feet. (See Cvijeta image.)

In Bosnia and Herzegovina women prepare knitted woolen slippers called *priglavci*. Although worn daily, new slippers adorn the body upon death. Shoes are not usually prepared as they are not put on the dead person, though this custom may vary in different regions.

Podbradak are small sheets of gauze, which are tied around the head in order to keep the mouth from being open. Sometimes they are used for tying legs too. Some women had prepared this as well. *Pokrov*, meaning "cover," is a plain white sheet made of cotton without any discreet patterns. The sheet is intended to cover the deceased, once the body is laid in the coffin.

The influence of Western European countries, especially Germany, Austria, and Switzerland, because of the large numbers of people from the former Yugoslavia who work in these countries as guest workers, can be seen in the presence of pillows. These pillows usually have a rough velvet cover and folksy motives that mimic those found in Bosnia. Pillows are also symbolic in that they connect to sleep and rest, and they also connect to beliefs in the afterlife. For example, in the past people believed that a pillow should be stuffed with hay rather than feathers to prevent the deceased from flying and then returning to disturb people.

Liza (Donja Vrba, Croatia), 2006

Source: Margareta Kern.

Cvijeta (Banjica, Bosnia and Herzegovina), 2007

Source: Margareta Kern.

Fashion also influences what women want to wear in death. A number of women exchanged a traditional item of clothing they already prepared (long cotton underwear trousers) for the new, more fashionable item, in this case a nylon petticoat.

Most of the women who prepared clothes for death lived in rural areas; those who resided in towns, however, were brought up in a rural area. Women who were displaced during the civil war in Bosnia and Herzegovina (1992–1995) had packed their clothes for death as the few important garments to take with them.

It is difficult to conclude an average age when most women prepare their clothes for death. They prepared some garments since their youth, adding other items later. Some women prepare their clothes for death when someone in the family dies. All the women inform their daughter or daughter-in-law about their death attire. In most cases family members know where the clothes are kept.

Little has apparently been written about the death clothing custom as it is currently practiced. What is available are contemporary texts that refer to the customs at the beginning of the 20th century and the late 19th century, showing that nevertheless the cultural, religious, and social significance of this custom continues to be of interest. One ethnographer of the early 20th-century period indicates that death had a meaning beyond losing an individual: It represented a

loss for the whole community. The symbolic importance of the continuation of community is shown from the 19th to the 20th centuries through the textiles, clothes, and jewelry of the period.

In the early 20th century it was expected of the young women of the village to prepare clothes for death for themselves, the husbands, and for the young children. Such outfits are similar to that worn on religious holidays such as Easter, Christmas, and to church on Sunday morning. The funerary customs clearly prescribed the type of clothes the person was to be dressed in during the festivities and also in death. These rules depended on age, marital status, and wealth. Young women were buried with a crown similar to that used in a wedding, even if not married. Young married women were buried with the clothing and the textiles they brought with them into the marriage.

Clothes for death have developed under varied influences, ranging from the great monotheistic religions to the old Slavic cultural heritage and pagan traditions. The rituals that surround and make up the funerary customs also have seeped into the religious and cultural beliefs: the concepts of hell, purgatory, heaven, God, saints and angels, the concepts of soul and death, afterlife, and the other world.

What people set aside for their burial has changed according to the fashion and social and cultural norms of the time. What has not changed is that people, predominantly women, prepare attire for their burial. They do not want to bring shame on their families by not being ready and presentable after their final hour. They are also preparing for a journey, with the clothing as a vehicle for traveling to the other world.

Finally, and despite the cultural influence among the elderly, this custom is disappearing from the cultural and social landscape of Croatia and Bosnia and Herzegovina, and probably other countries of the Balkan region as well. Documentation of this dying cultural artifact provides important insights as well as a new way of looking at clothing. Something that binds us so much to the earth and the world of appearances and presentation can also serve as a safe space to contemplate and imagine the unimaginable: time when disappearance rather then appearance will be of importance.

Margareta Kern

See also Literary Depictions of Death; Photography of the Dead; Pre-Need Arrangements

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Columbarium

Columbarium (plural columbaria, columbariums) refers to a structure designed to hold the cremated remains of multiple individuals. The term derives from the Latin *columba*, meaning "dove" or "pigeon," because the remains are placed within individual recesses that resemble those of dovecots. Columbaria were first built in Italy during the late 1st century B.C.E. and usually housed the cremated remains of nonélite members of Roman society. They were sometimes associated with the household of patrician Roman families or funerary clubs (associations that guaranteed burial for

their members). Roman columbaria were a purely urban phenomenon and, although examples have been excavated throughout Italy, nowhere have they been found on the same scale or in the same numbers as the environs of Rome. When cremation was superseded by inhumation during the 2nd century C.E., columbaria fell out of use in Europe, reemerging as a feature of the cemetery environment only in the late 19th century as Europe and the United States once again embraced cremation.

Ancient Columbaria

Roman columbaria varied in size and, although some accommodated several hundred urns, most were relatively small, housing between 50 and 100. They are often described as subterranean chambers when, in fact, many had levels constructed above ground. In essence they comprised one or more rooms, their walls lined with small semicircular or rectangular niches (*loculi*). These niches were designed to house cinerary urns, either individually or in small groups. Below the *loculus,* space was reserved for a small inscribed plaque (*titulus*), which recorded the name and personal details of the individual(s) whose ashes were interred there. The space could also be painted with the same details rather than incurring the expense of an inscribed epitaph. This practice reflects the strong desire for commemoration that was held by all members of the Roman community, regardless of social status.

In some instances, the individual loculi were sealed with decorated plaster, marble, or tile, and sometimes the surrounding area was embellished with brightly colored frescoes and stucco to distinguish the niche and its occupants from the many others within the columbarium. Small mythological scenes and themes from nature, including flowers, fruit, and birds, were commonly selected for this purpose. The owners of each loculus were responsible for its decoration and this, along with the recording of names, occupations, and relationships in the epitaphs, sheds light on the lives, beliefs, and concerns of the people who used columbaria.

The best-preserved ancient examples of columbaria include those of the so-called Vigna Codini on the Via Appia, and the Columbarium of Pomponius Hylas, on the Via Latina, which were built during the early 1st century C.E. The three Vigna Codini columbaria contained the remains of many slaves and freedmen (former slaves) of the Julio-Claudian dynasty, including ex-slaves of Livia, wife of Augustus. Some wealthy patrons constructed columbaria specifically for their slaves and freedmen, such as that built by Statilius Taurus on the Via Praenestina, which accommodated over 700 burials. The inscribed dedications and epitaphs associated with individual burials within these structures occasionally record heirs and other family members, consequently revealing much about household, personal, and conjugal relationships among many of the important families of the Augustan period. The fact that many slaves and freedmen of the same household were interred together reflects the perceived importance of continued membership of the specific identity group to which they had belonged in life. In other instances, columbaria were built by a cooperative body or burial club (*collegium*), with loculi allotted or sold either individually or in groups. The individuals interred within these columbaria may have shared no connection in life.

Ancient columbaria were one response to the problem of high levels of urban mortality. They facilitated mass disposal of cremated remains, while continuing to observe religious and social demands for remembrance. However, during the late 1st and early 2nd centuries C.E. the design of columbaria evolved, becoming smaller and more focused on the family group (still including slaves and freedmen). Large structures capable of accommodating hundreds of urns were replaced by enclosures and aboveground chambers, such as those of the Via Laurentina at Ostia, or "house-tombs," found at Isola Sacra and the Vatican necropolis. Usually built by freedmen, these tombs closely resembled houses, with doorways placed beneath a cornice and triangular pediment, but their interior walls remained lined with loculi in the manner of earlier columbaria. As inhumation began to replace cremation as the predominant rite of disposal across the Roman world, these

tomb structures were adapted to accommodate burials and no new columbaria were built.

Modern Columbaria

In some parts of Asia the storing of ashes in columbaria has long been associated with Buddhist temples; however, in other cultural contexts, the construction of modern forms of columbaria is a relatively recent phenomenon. In the late 19th century the true columbarium, as a place for the collective storage of individual cremation burials, began to appear as a feature of the urban environment of Europe and the United States, partly in response to the return of cremation as a recognized form of body disposal. A columbarium was built in the famous Père Lachaise cemetery in Paris in 1889, and the architecturally celebrated San Francisco Columbarium opened in 1898. The first purpose-built example in the United Kingdom (the West Columbarium, 1901) was designed by Ernest George as part of the Golders Green Crematorium in London.

Today columbaria are commonly constructed in association with churches or the chapel buildings of a crematorium. These structures retain the use of recess-lined walls for the interment of ashes, with space available for the deceased to be commemorated. In many modern columbaria the niches are filled with memorabilia associated with the deceased and sealed by glass; this is a practice seen at the Bohemian National Cemetery in the United States (1919), and more recently at the Benešov Cemetery in the Czech Republic. Photographs are now commonly used to identify the deceased.

Like their ancient equivalents, modern columbaria across the world reflect the pressures imposed by increased urbanization and its associated demands for affordable and accessible burial space. The Choa Chu Kang Columbarium in Singapore illustrates the enormity of many modern columbaria; it contains 147,000 niches distributed over 18 four-story blocks. In China and Hong Kong, elaborate new columbaria have arisen as a consequence of official government encouragement of cremation since the 1960s. However, in Europe, the increasingly popular practice of scattering ashes has led to a decline in the construction of purpose-built columbaria.

Emma-Jayne Graham

See also Cemeteries, Ancient (Necropolises); Cremation; Cremation Movements; Tombs and Mausoleums

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Commodification of Death

In modern societies death has become a commodity; people pay for goods and services in order to pay their last respects to the dead. This commodification of death occurred in the past 2 centuries with the emergence of the professional undertaker. Before that, neighbors, relatives, and charities took care of the handling of dead bodies. Since ancient times, however, people might have offered something valuable in exchange for death-related, ritual services and goods. The Tiwi Aborigines from north Australia are a case in point, showing that the commodification of death is not necessarily a modern phenomenon and limited to industrialized societies. In olden times these hunter-gatherers had elaborate mortuary rites in which ritual workers were paid with paraphernalia, spears, and other artifacts. Later on, in the 20th century, Australian dollars were introduced, along with printed fabrics in traditional designs, to this end. The cloths first used to be hung on

lines around the grave, where they bore witness to the donors' conspicuous consumption. It was only in the second half of the 20th century that serious attention was drawn to the commodification of death in relation to the American undertaking business.

Jessica Mitford's book *The American Way of Death,* first published in 1963, radically changed the public image of the funeral industry. Allegedly the industry exploited the grief-stricken and vulnerable survivors of the newly dead. Scheming to maximize their profit, in Mitford's view, undertakers had cleverly developed many ways to overcharge their customers and even sell them goods and services they might not need. The best-selling book had a long-lasting impact on the public's view of the funeral industry. Earlier, novelist Evelyn Waugh, in his 1948 book *The Loved One*, painted a bleak picture of the undertaking business in southern California, where the commodification of death was taken to its extreme. No matter if the corpse was disfigured, it had to be embalmed and displayed in an expensive casket. Memorable from Mitford's book are the tactics employed in the sale of coffins and the money that could be made from offering costly final destinations for the human remains and their memorialization. She also put the necessity of embalming, key to "the American way of death," under scrutiny.

Recently Gary Laderman reviewed the shockwave that Mitford's book sent through the industry in his history of the funeral home in 20th century America, titled *Rest in Peace*. Laderman lets the undertaking business off the hook. The position of the undertakers (or funeral directors, as they later became known) was a vulnerable one because they were dealing with death. Many felt that commerce should not intermingle with this deeply felt human experience. What is more, undertakers handled corpses behind the scenes, and exactly what they did with the bodies became a figment of the popular imagination. The general public's ambivalence toward death, rather than the exceptional cases of exploitation, appears to have been the main reason for the emergence of a negative stereotype of the profession. According to Laderman, Mitford's exposé of the tricks of the trade met with its great success because the author had woven this stereotype into her account. Laderman, to the contrary, stresses that Mitford turned a blind eye to the cultural motivations of the customers. Furthermore, he notes that in actual practice, undertakers developed good contacts, if not relations of trust, with other members of the community.

Increased organization and rationalization of the undertaking business contributed to a nationwide uniformity of funerals. It also led to the formation of larger companies, and even multinational corporations that took over family-owned funeral homes. The conglomerates in turn were unfavorably compared to the small and more personal, community-based funeral homes. Changes in the U.S. immigration policy forced the funeral industry to cater to consumers from various ethnic and religious groups, as well as the subsequently increasing popularity of cremation. At the same time, changing consumer desires offered the industry the opportunity to sell a proliferation of services and goods. This was also a result of fiercer competition due to increased life expectancy and more people entering the business. Undertakers kept control over the corpses, but the stigma evaporated to a large extent because death was embraced by popular culture, and mortuary rites turned into celebrations of the deceased's life. Although secularization made inroads, and cremation and the preservation or scattering of ashes were added to the repertoire, the funeral directors remained the ritual specialists dealing with the dead. While being innovative in accommodating a plethora of consumer desires and new ritual gestures and goods, they stuck to the old pattern. In spite of criticism, the commodification of death thus did not disappear; to the contrary, it increased.

Similar developments occurred elsewhere, such as in the Netherlands, even though embalming is not a standing practice there yet. Remarkably, the support provided by the funeral industry in the Netherlands to ordinary people to conduct death rites themselves is in striking contrast to the situation in Japan, where the acquisition and control of funeral knowledge by the industry has discouraged ordinary people from doing so. The transition from "community funeral" to "commercial funeral" in Japan has been analyzed by Hikaru Suzuki in *The Price of Death*. In another way, a commodification of death occurred in Oaxaca, Mexico, with regard

to the Day of the Dead, frequented by many tourists every year who are eager to buy commodities and souvenirs related to the annual death ritual. The mortuary rites and artifacts of the Torajans of Sulawesi, Indonesia, are another example of commodification in relation to tourism.

Funerary fairs and open days of funeral homes and crematoria showcase the commodification of death in the Netherlands, as they do elsewhere, to potential customers. An ever-expanding and wide range of goods and services have become available. These include special meals (e.g., champagne and oysters), various means of transport (such as an old-fashioned carriage with horses, bicycles, or bus and limousine), all kinds of caskets (or just a plank or shroud and cradle-like baskets for stillborns), manifold floral arrangements, mourning jewelry containing ashes, grave gifts such as cuddle toys and various placatory gifts, headstones and statues. In some European countries a substantial proportion of business relating to the floral business is related to flowers for the dead. Artificial flowers, made in the People's Republic of China, also figure in the traditionally oriented death rites of the aforementioned Tiwi.

Interestingly, once commodities, such as teddy bears and other cuddle toys, have served the function of grave gifts, they can no longer be treated as commodities. The act or ritual gesture takes them out of circulation. It makes the objects sacrosanct. Death thus provides an important context for decommodification. In this context commodities acquire new and priceless values that put them beyond reach of market transactions.

Eric Venbrux

See also Day of the Dead; Funeral Home; Funeral Industry; Funeral Industry, Unethical Practices; Funerals and Funeralization in Cross-Cultural Perspective

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Communal Bereavement

Communal bereavement is the widespread experience of grief and distress felt among people who did not know and never met the deceased. It is expressed in mass gatherings of mourners, such as vigils or memorial services. Mass acts of condolence for the deceased and their loved ones, such as leaving notes, flowers, or other gifts and mementos at symbolically important locations, are also manifestations of communal bereavement.

The critical aspect of communal bereavement is that many of the mourners do not personally know the deceased person or persons. Moreover, many of those experiencing communal bereavement did not have a direct social tie to the deceased person or persons. With communal bereavement, the grief and distress extend beyond the social network of the departed to the larger community. This aspect of the phenomenon makes it communal.

Examples of Communal Bereavement

Communal bereavement most commonly occurs after tragic—often violent—unforeseen deaths. In particular, communal bereavement is most common when an act calls into question the basic values or commonly held perceptions of the community. Community bereavement is also common when institutions vital to the normal functioning of a community fail to competently perform essential tasks, especially tasks central to the provision of security. It also occurs after the deaths of popular political figures, such as Diana, Princess of Wales, or Argentinean First Lady Eva Perón. Communal bereavement may also occur after the death of popular cultural icons, such as what occurred after singer John Lennon was murdered.

Among the most common causes of communal bereavement are acts of mass violence that result in large numbers of victims. For example, widespread communal bereavement took place after the 1995 bombing of the Alfred P. Murrah Federal Building in Oklahoma City, Oklahoma. This terrorist attack killed 168 people and injured over 800 others; yet, the grieving extended far beyond those victims and their immediate social circle. Similarly, the 9/11 terrorist attacks against the United States, which resulted in nearly 3,000 deaths, caused people worldwide to experience grief and express their sorrow. People in towns and on college campuses across the globe held vigils and made other expressions of communal bereavement after the mass murder of 32 students and faculty members on the Virginia Tech campus in April 2007. Similar scenes were witnessed after the February 2008 shooting at Northern Illinois University that resulted in five murdered students. Across the nation's universities and colleges, students offered support by conducting their own vigils and memorial services. The 1999 Columbine High School (Colorado) shootings also resulted in widespread communal bereavement.

Natural disasters can also result in communal bereavement. Thousands of people worldwide expressed distress after Hurricanes Katrina and Rita devastated the American Gulf Coast. Similarly, the 2004 tsunami that killed nearly 230,000 people in 11 countries led to worldwide communal bereavement. The sheer destruction caused by these events was likely sufficient to cause communal bereavement, yet these events also raised issues of the competency of our institutions to protect us from natural disasters.

Although "routine crimes" such as a murder with one or two victims typically do not lead to widespread communal bereavement, it does occasionally occur when the "routine crime" is particularly heinous and offends strongly held collective sentiments. For example, after Susan Smith murdered her two young sons by drowning them in a South Carolina lake, thousands of people across the United States and around the world expressed their grief by placing flowers, small gifts, and letters at the shores of the lake. A similar example of communal bereavement for a lone victim occurred in February 2000. When a classmate fatally shot Kayla Rolland, a 6-year-old student at Buell Elementary School in Flint, Michigan, the community openly mourned. Nearly 1,000 residents expressed their grief at vigils, memorials, and her funeral.

Outcomes of Communal Bereavement: Distress at the Individual Level

Research on the effects of widespread distress associated with communal bereavement has identified a number of negative outcomes at the individual level. Communal bereavement can produce effects on both the body and mind of those who experience it by producing stress and can lead to a number of somatic illnesses associated with stress. For example, Ralph Catalano and Terry Hartig report that shortly after an assailant shot Swedish Prime Minister Olof Palme on February 28, 1986, 26% of surveyed Swedes cried and 10% reported feeling sick. To explore whether the prime minister's death caused more severe health problems, these analysts tested the hypothesis that the incidence of very low birthweight babies rose significantly in Sweden immediately after the assassination. They also hypothesized that low birthweight births would increase after the death of 852 persons in the sinking of the ferry Estonia in 1994. Analyzing quarterly data from 1973 to 1995, the researchers found that the Palme assassination was associated with approximately a 21% increase in the quarterly incidence of live births of infants weighing less than 1,500 grams (the clinical definition of very low birthweight). The sinking of the Estonia was associated with an increase of approximately 15% in low birthweight births. These effects were observed even after controlling for other stressful events, such as male unemployment rate, average temperature, and other relevant factors.

Researchers found similar effects on birthweight after the 9/11 terrorist attacks. In New York City, there was an increase in very low and moderately low birthweight babies after the attack. While the effects were not as strong, the 9/11 attacks were also associated with increased chances of very low birthweight in upstate New York. It was concluded that the communal bereavement associated with the terrorist attacks affected individuals far beyond those who witnessed the event. The widespread communal bereavement associated with the 9/11

attacks also appear to be associated with a drop in the male-to-female sex ratio in both California and New York. Apparently, even in individuals who did not know the victims, communal bereavement produces stress hormones that can induce spontaneous abortions and premature labor.

In addition to effects on physical health, communal bereavement may produce adverse mental health effects. Researchers in South Australia found a dramatic increase in the request for, and use of, grief support and counseling services 3 weeks following Princess Diana's death. After the Oklahoma City bombing it was reported that among more than 3,000 Oklahoma City area students, those with close relatives who were injured or killed in the bombing had higher posttraumatic stress levels. However, levels of posttraumatic stress disorder also were elevated even for those who did not have close relatives injured or killed in the attack. Similarly, approximately 6 months after the 9/11 terrorist attacks, 1 in 4 of approximately 8,000 New York City children studied demonstrated anxiety and emotional symptoms related to the attacks. Mental health services at Virginia Tech reported an increase in requests for services after the mass shooting that occurred there. The request for counseling services was significantly higher when students returned for classes the following fall than in previous fall semesters.

Researchers have frequently found gender differences when analyzing the impact of communal bereavement on physical and mental health. In general, females are more likely to experience health problems than are males. Among the children evaluated for posttraumatic stress disorder after the Oklahoma City bombing, there were significant differences, with girls having higher symptom levels than boys. Similarly, girls reported a significantly higher level of fear after the 9/11 attacks than did boys. Among students who did not personally know a victim of the Virginia Tech shootings, females were nearly twice as likely to seek counseling after the tragedy as were males.

Regardless of the nature of the effect, this line of research highlights that communal bereavement leads to heightened stress. In turn, increased stress levels cause somatic illnesses and adverse mental health effects. This research implies that the effects of tragedies and disasters extend far beyond those directly associated with the events.

Outcomes of Communal Bereavement: Solidarity at the Community Level

While communal bereavement is associated with individual-level distress, it also acts as a source of community solidarity or cohesion. What leads to an increase in solidarity is the intensity of social interactions that transpire after tragic events or disasters. Events that cause widespread communal bereavement typically produce collective responses. For example, on the day after the murders at Virginia Tech, over 10,000 people attended a convocation held to honor the victims. That night, thousands of people attended a candlelight vigil. On the Saturday after the tragedy, thousands of students and town residents attended a picnic hosted by a community group on the university's campus.

As large numbers of persons focus their attention on the event and participate in mass rituals of communal bereavement, a collective mood sweeps over them. Because the sentiments that were violated are widely held and respected, violation of them threatens the group's collective identity. The collective, in turn, resists this threat by acting collectively. This collective action promotes the group's solidarity and enhances its unity.

There are numerous examples of widespread communal bereavement resulting in heightened group solidarity, such as the surge in social solidarity observed after the 9/11 terrorist attacks. The elevated levels of solidarity, expressed through heightened levels of nationalism and national pride, lasted approximately 6 months after the attacks. By 9 months after the attack, levels of solidarity had returned to their preattack levels. Similarly, social solidarity increased significantly after the Virginia Tech shootings. Comparing data measuring levels of community solidarity that were collected in 2006 with similar data collected after the tragedy, researchers found that levels of solidarity increased by over 20%.

Like the individual-level effects of communal bereavement, the solidarity-producing effects of communal bereavement may vary across subgroups. Among a sample of undergraduate students at a small liberal arts college, the boost in patriotism after 9/11 was much more marked among

white students than among black students. As compared to black students, white students were 4 times more likely to say that the attack greatly increased their feelings of patriotism. Moreover, white students were twice as likely to believe that the attacks precipitated closer bonds to others. Despite these differences, all students in the study felt heightened levels of patriotism and solidarity.

The increased solidarity associated with widespread communal bereavement serves as a protective factor for the members of the community experiencing the trauma. Enhanced community solidarity helps foster and sustain social support networks that can reduce the adverse effects of communal bereavement as the relatively unstressed community members provide coping resources to those community members who experience more stress. Research on tragedies and disasters reports remarkably consistent findings regarding the ability of people to rely on existing informal support networks to help them through the bereavement process. These findings hold true regardless of the type of disaster or the country affected by the tragedy. Because of this consistent finding, mental health practitioners who respond to mass tragedies include "connection with social supports" as one of the primary goals of "psychological first aid." Thus, a comprehensive community health response to disasters should reduce distress by structuring opportunities for contacts with primary support persons or other sources of support, including family members, friends, and community members. Research clearly indicates that utilizing social support networks can reduce the adverse effects of communal bereavement. But even with social support, some members who experience communal bereavement are unable to avoid the onset of somatic illness or mental health problems.

James Hawdon

See also Bereavement, Grief, and Mourning; Disasters, Man-Made; Disasters, Natural; Funerals; Grief, Types of; Massacres; Memorials; School Shootings

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Communicating With the Dead

Humans relate to the dead in a variety of ways, which may or may not entail an experience of communicating with the dead. As communication is an inherently social activity, the ways in which communicating with the dead has been socially framed are addressed first, before going on to look at those cultures that provide no such frame, and finally certain experiences that are seemingly unframed. The entry takes the stance of the anthropologist or student of religion who attempts to describe human experience; the entry neither reduces experiences of communicating with the dead to biological or psychological processes, nor considers whether they could provide evidence of the supernatural.

Socially Framed Communications

Mutual Care

In many societies, there is a relationship of mutual care between the living and the dead. The dead need the help of the living on their journey to heaven (as in Catholic and Orthodox Christianity) or to the status of ancestor (as in much of East Asia). Catholics, for example, pray to the saints (a particular category of authenticated pious dead) for the souls of those they care for. In Japan, offerings are made to the dead at certain places (the household shrine or public Shinto shrines) and certain times (the O'Bon Festival in mid-August when the dead return to earth). In return, the dead are consulted for guidance, again typically at these times and places. A *shrine* is a place where the living may care for, and be guided by, the dead.

In a number of cultures and religions, distinctions are made between the recent dead and those who have become ancestors, typically after two generations have passed and there are few if any living who personally remember them. Among the Shona of Zimbabwe, for example, supplications are made to the ancestral spirits (the long dead) through the intermediary of the living dead (the recent dead). Ancestorhood usually reflects not personal affection for the deceased but the continuance beyond the grave of familial authority relations; in Africa, this relation with the ancestor may be more one of fear than of care.

In addition to these family ancestors, there are also the sacred dead legitimated by powerful institutions such as the state (national heroes, the war dead) or the church (saints); communications with these sacred dead are controlled by the relevant institution. In Japan, those who have died in war for their country attain the status of divinities, and so care between the living and the dead is particularly pronounced in rites performed at the Yasukuni national shrine for the war dead.

Reincarnation Within the Family

In a number of African and North American Pacific Coast societies, there is a belief that the spirit and character of a dead person may be transferred to a living child or newborn baby. Among the Shona, a child may be given the name of a living grandparent, and be related to as though he or she were the grandparent; after the elder's death, the child receives the personal character of the deceased. In such societies, there is a strong sense that the dead can manifest themselves within the living, and by implication take part in the communications of everyday life. In Western countries without this tradition, there is the idea of a child bearing a strong likeness to an older relative, but this is explained in terms of genes, and, as Roland Barthes has observed, photographs comprise a way in which the dead manifest themselves among the living.

Continuing Bonds With the Dead

In many societies, the boundary between the living and the dead is relatively permeable, and it is accepted that the living may chat to the dead. This is, for example, normal and even expected behavior at a Japanese household shrine. Even in communist, secular China, guidance may be sought about business decisions from the ancestors, and in Japan an office building may have its own shrine. This is common in societies where filial piety is strong: The elders are respected and their advice sought in life, and there is no reason why this should cease in death. This assists the living and legitimates respect for elders.

The Unquiet Dead

If the dead are expected to journey steadily away from the material land of the living—whether in the direction of heaven, reincarnation, or ancestorhood—this journey may be impeded by a number of factors. The living may cling to them, and the dead may cling to life. They may have died suddenly or violently, or been denied the correct rituals on their deathbed or at the funeral. Others may have no living descendents. These lonely, troubled dead hang around, too close to earth for our comfort or their good. Though ghosts are not always of this troubled nature, seeing or hearing a ghost or vampire can in some societies be taken as evidence that a particular deceased person is not at peace. They require rituals to send them correctly on their way. Exorcising a haunted house, for example, is believed to put a stop to unwanted visits by the dead.

Throughout the 20th century in England, many who visited mediums or a spiritualist church were concerned about the unquiet state of a deceased relative, such as a child who had died violently. (Spiritualism was very popular after World War I.) The message received from the other side in spiritualist churches in England today is typically, "He's okay, he loves you, and wants you to get on with your life."

The Banned Dead

The Judeo-Christian tradition has banned the use of mediums to contact the dead. Judaism memorializes the dead but discourages active communication with them. For Catholic and Orthodox Christians, the saints may be contacted through the prayers of the church, while in Protestantism all contact with the dead is wrong—though some individual Christians on occasion quietly consult

mediums. Other belief systems, such as secular materialism, state that it is impossible for the living and the dead to communicate with each other, because the dead no longer exist. Hence the historically Protestant, now largely secular, societies of northwest Europe and, to an extent, North America, have little space for communication with the dead.

If contact with the dead is impossible, or wrong, then people are left largely with memory. This is all there is, as the dead cannot be cared for, feared, or prayed to. So in the West there are war memorials, where the living remember those who sacrificed their lives; in contrast, Japan has shrines where the living can care for the war dead and be guided by them.

Even in societies that ban contact with the dead, people may have some of the experiences discussed in earlier sections of this entry. They may pursue the experience, but in private, as it is not socially validated. A mourner may talk to a deceased husband, parent, or child, but privately, or at the graveside when there are few people around. Caring for the grave, by keeping it clean and the flowers fresh, may be experienced as a way of continuing to care for the person.

In Anglo American society, which largely bans the dead, subcultures have developed that feature communications with the dead. Ghost stories, haunted houses, jangling skeletons, and gothic misty churchyards have been part of English and American literary and popular culture since the late 17th century and continue today in British goth subculture and in Hollywood horror movies. All these are largely absent in Catholic Mediterranean Europe or, if present, are recognized as Anglo imports.

Modern Western societies, especially U.S. society, have, however, instituted one particular way in which the dead leave powerful messages for the living, namely philanthropy. Philanthropists leave exceptionally clear instructions for how their postmortem fortunes are to fund good causes, and would-be recipients must listen carefully to the deceased's conditions if they are to be successful in their bids for funds.

Since the 1990s, secular psychological theories of grief allow that mourners may continue various kinds of bonds with the dead. This opens up a space in which even secular materialists and devout Protestants can accept relationships, if not actual communication, with the dead. Without formal religious legitimation, however, these continuing bonds are seen as just a psychological need.

Other Communications

Other communications are highly individual and, less obviously, either socially framed or culturally banned. They are also more closely tied to dying and mourning.

Nearing death awareness is when someone on their deathbed reports an experience that includes a deceased family member, who may appear to be welcoming them. In Britain, such experiences are rarely reported to doctors, more often to nurses or family carers; in Ireland, such experiences are well known and part of folk culture.

Near-death experiences occur when someone is clinically dead, often because of a sudden cardiac arrest, and include a range of experiences, one of which is a sense of going down a tunnel at the end of which is an image of light, often interpreted as an angel or a divinity. The figure is rarely, however, interpreted as a known deceased and therefore cannot properly be counted as a communication with the dead.

The sense of presence is the perception, through sight, sound, or smell, of a deceased loved one. It comes unbidden, and is therefore different from employing a medium to contact the dead. It may occur months, years, or decades after the death. Like the near-death experience, it has been well-documented over the past 40 years. Whereas earlier researchers found that informants often said they had not previously mentioned the experience to anyone, this is now not the case; the sense of presence seems to be gaining a measure of legitimacy.

Explanations

There are two kinds of popular literature about nearing death awareness, near-death experiences and the sense of presence. On the one hand, rationalists attempt to explain them in terms of psychology or biology. Thus the sense of presence is seen as a part of the grief process, or the near-death experience is explained in terms of brain chemistry. On the other hand, supernaturalists use such experiences as evidence of God or the supernatural.

Both rationalists and supernaturalists are entitled to their views, but a social science approach is different. Because every human experience undeniably has a biological component, there is clear merit in exploring the biochemistry of unusual experiences; and throughout history, unusual experiences have shaped religious beliefs. But to *reduce* experience to biology, or to see it as *proof* of the supernatural, are both acts of faith. Alternatively, communications with the dead can be seen as, in the broadest sense, religious experiences. The social scientist may document these experiences, both from the inside (by gathering first-hand narratives and by participant observation) and from the outside (by documenting the legitimation, pathologicalization, and cultural history of such experiences).

Tony Walter

See also Ancestor Veneration, Japanese; Day of the Dead; Memorials, War; Near-Death Experiences; Shinto Beliefs and Traditions; Spiritualist Movement

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Condolences

When someone who is cared about suffers the loss of a loved one, it is appropriate to offer condolences, or expressions of sympathy. Though condolences may be delivered by way of conversation, it is the letter of condolence that has received more popular and scholarly attention. The letter of condolence dates back at least as far as 45 B.C.E., when Servius Sulpicius Rufus wrote to console Marcus Tullius Cicero upon the death of his daughter during childbirth.

Any communication regarding a devastating event has the potential to be upsetting. Therefore, though a letter of condolence should be honest and heartfelt, some degree of planning and foresight might be appropriate to help ensure that its actual impacts are the intended positive ones. Understanding the common features and foibles found in exemplary letters of condolence may improve the odds of creating and appreciating effective ones.

Common Features of the Letter of Condolence

An offering of condolence will generally include acknowledgment of the loss and grief of its target as well as an expression of empathy, sympathy, or both. It will often also provide an effort aimed at comforting the bereaved.

It is standard form to disclose one's emotions about the loss with statements such as, "I am so sorry" or "I share in grieving." Moderation and brevity are valued in letters of a sensitive nature, especially when concerning the expression of emotion. It is likely that overwrought portrayals of hair-pulling anguish will not be comforting to the bereaved.

Statements asserting that the deceased was appreciated, lived a good and worthwhile life, and will be missed by others may be of great consolation to those in mourning. Therefore, consolers are well-advised to note admirable qualities and values of the deceased and to revisit special memories. Recognition of the void left by the loss of the person may be counterbalanced by determination to preserve the relationship with that person. The bereaved may be comforted to know that the deceased will be "kept alive" in the thoughts, values, and actions of others.

Those who offer condolences should be careful not to assume they are privy to the feelings of the grieving target. So, statements like "I'm sure you are devastated" or "You must be beside yourself"

should be avoided. Moreover, the fine line between empathy and sympathy should be respected. One should only claim to know what the experience is like if one has already been subjected to it.

Comfort may be derived from nonspecific offers to help the bereaved. It would be presumptuous to expect that every survivor of grief would find equal value in the same form of assistance. Though a consoler's specialty may be cooking, an offer to bring food may or may not be appreciated. It is better to express one's willingness to help either in general or across a range of options, such as a physical act of assistance, through conversation, or just by being available when needed.

In reviews of condolences, scholars have identified less common alternative inclusions. The first of these is to share one's own grief accounts to offer insights or exhibit sympathy by way of solidarity. Another device included in some letters of condolence is the citing of a well-chosen reading from literature or scripture. Finally, some consolers provide potentially helpful perspectives on the loss by imparting a philosophy about life, death, or both. Care should be taken not to espouse religious beliefs that are contrary to those of the reader.

Brevity is likely to be a virtue within the letter or note of condolence. Long-winded, overly detailed stories about the deceased should be parsed down. Indicators of emotions should be expressed briefly with vivid terms such as used in the statement, "I was shocked and dismayed by your loss." Updates about one's own family and circumstances should be saved for a future correspondence.

Rather than the pedestrian "Sincerely" or "Yours truly," letters of condolence often conclude with a phrase such as "We are all thinking constantly about you" or "Your family has my sincerest sympathy and regards."

Exemplary Letters of Condolence

The authors of some noteworthy letters of condolence stand out for their exquisite renderings of grief and emotion. Thomas Jefferson told John Adams, upon the death of the latter's wife, Abigail, that "I will not by useless condolences, open afresh the sluices of your grief." To console Thomas Mann, whose son committed suicide, Herman Hesse wrote, "Like all your friends, we have received the sad news with consternation and profound sympathy."

Some letters offer praise amid their touching portrayals of the lives and characters of the deceased they mourned. Sir Samuel Hoare wrote Neville Chamberlain's widow that of all the public men he had known, Chamberlain was the most humble and had "nothing artificial or insincere about him." Robert Louis Stevenson told Charles Baxter his father was "one of the best, the kindest, and the most genial men I ever knew."

Others provide a helpful perspective of death as the end of suffering, the desire of a greater being, or the beginning of a superior state of being. Ralph Waldo Emerson wrote about Jane Carlyle to Thomas Carlyle, "I must think her fortunate also in this gentle departure, as she had been in her serene and honoured career . . . and you will have the peace of knowing her safe and no longer a victim." Benjamin Franklin reminded his niece when her father died that "it is the will of God and Nature that these mortal bodies be laid aside, while the soul is to enter into real life."

Finally, writers of notable letters of condolence sometimes offer support in the form of general aid and assistance. John Donne told his mother, upon the loss of the last of his five siblings, "I do, and ever shall, esteem myself to you and provide for your relief." Emily Dickinson reminded a bereaved friend, "When not inconvenient to your heart, please remember us, and let us help you carry it, if you grow tired."

Michael Robert Dennis

See also Bereavement, Grief, and Mourning; Elegy; Epitaphs; Eulogy; Language of Death

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Confucian Beliefs and Traditions

Confucianism can be characterized as a nontheistic and humanistic religion, with no rigid creed system and yet with rich systems of ritual. In Confucianism, what one believes is subordinate to what one practices. This distinctive aspect of the Confucian tradition has induced a context in which disparate ideas and beliefs could have coexisted, and yet a uniform system of ritual has been established through ritual manuals. Similarly, there has been a wide spectrum of ideas about death and the afterlife, but the Confucian tradition has established standardized death rites that involve the funeral and ancestral ritual. They have been considered as the most essential rituals in Confucian life, their primary rationale being the fulfillment of "filial piety," one of the core Confucian values.

The Confucian Approach

The *Analects,* the most important and influential book among the Confucian corpus, includes a short dialogue between Confucius and one of his disciples about death and serving the spirits of the dead. When Confucius is asked about serving the spirits of the dead, he says that while we are not yet able to serve fellow human beings, how can we serve the spirits of the dead? In response to a question on death and the afterlife, Confucius remarks that while we do not yet know life, how can we know death and the afterlife? This dialogue shows not so much Confucius's agnostic attitude toward death and the spirits of the dead as his primary concern with human life in this world. Given the importance of the *Analects* within the Confucian tradition, it is not difficult to recognize the extent to which those statements have influenced later Confucian discourse on the issue of death and the afterlife. In fact, that short dialogue sums up the basic approach of the entire Confucian tradition toward the issue. One could even argue that it epitomizes the general characteristics of the whole Confucian tradition: That is, while not being indifferent to the issues of supernatural beings and life after death, Confucianism is more concerned with human society in this world. In the humanistic framework of Confucian thinking, therefore, the issue of whether there is an afterlife and whether the spirits of the dead continue to exist is secondary to more primary concerns such as the issue of self-cultivation and social participation.

This, however, is not to say that Confucianism has little discourse and practice in relation to death. On the contrary, from its earliest early period, the Confucian tradition produced a variety of ideas about death and the afterlife, ranging from belief in the continued existence of ancestral spirits, to an agnostic approach, and to disbelief in the afterlife. In general terms, the latter view became dominant in later Confucianism, which claims that human spirits disperse soon after death. Admittedly, the issue of death and the afterlife has not occupied the principal place in Confucian scholars' thinking, and the Confucian tradition has not produced unified systems of thought or belief in relation to death and the afterlife. The Confucian tradition, however, has developed a sophisticated system of death rites, perhaps the most sophisticated among major world religions, involving the funeral and ancestral rites.

Ritual lies at the heart of the Confucian tradition to the extent that Confucianism could be described as a religion of ritual. Confucians have ritualized all domains of life and have emphasized ritual practice as a crucial means of realizing Confucian ideals such as self-cultivation and social harmony. The simple fact that ritual texts (i.e., the *Book of Rites,* the *Ceremonials,* and the *Institutes of Zhou*) were included in the Five Classics exemplifies the significance that ritual has taken in the Confucian tradition—the other four titles of the Five Classics are the *Book of Changes,* the *Book of History,* the *Book of Poetry,* and the *Spring and Autumn Annals*. Confucius has always been regarded as an expert on ritual and, following his example, many subsequent Confucian scholars have immersed themselves in the study and practice of ritual. Of the various Confucian rituals,

particularly influential in the life of ordinary people and the elite alike have been death rites—the funeral and ancestral ritual. These, along with two other rituals of cappings (coming of age) and weddings, constitute the four Confucian family rituals. Death rites have been the most important among the four family rituals. The extent to which death rites are important in the Confucian tradition can be illustrated by a simple fact that Zhu Xi's *Family Rituals*, one of the most influential ritual manuals in East Asia, allocates some 87% of the main text for chapters dealing with the funeral and ancestral rites. As a ritual expression of "filial piety," they have constituted the foundational rituals of the Confucian family and society.

Funerals

The Confucian funeral uses burial as its method of body disposal. While Buddhists cremate their dead in the hope that they would reach paradise without delay, Confucians practice burial in the expectation that the body be returned intact to the ancestors: Confucians oppose cremation as it is considered degrading to the parents' bodies and thus against Confucian teachings of filial piety. For Confucians, a well-preserved grave is understood as an expression of filial piety as well as a guarantee for the well-being of both the dead and the living. An influential and yet controversial practice in relation to burial concerns what is commonly translated as "geomancy" in Western literature. Its East Asian equivalent, *fengshui* in Chinese and *pungsu* in Korean, literally means "wind and water" and is basically concerned with choosing auspicious sites for the living (i.e., when building houses, planning cities, and locating temples and shrines) and for the dead (i.e., when situating graves). In particular, the theory and practice of grave geomancy has deeply influenced the life of ordinary people and intellectuals alike in East Asia. Throughout history, Confucian scholars have shown various attitudes toward this grave geomancy ranging from the very critical to the favorable. For instance, while Zhang Zai (1020–1077) and Cheng Yi (1033–1107) considered geomancy irrational, Zhu Xi (1130–1200) upheld the practice of geomancy and observed it himself, especially in burying his family members. Zhu Xi also wrote a geomantic *Discourse on Royal Tombs* (*Shanling yizhuang*), which was presented to the Chinese emperor in 1194. During the Joseon dynasty of Korea (1392–1910), the most Confucianized state in history, many Confucian scholars were experts on geomancy and accepted the practice of geomancy to varying degrees. In imitation of the Confucian elite and also as part of popular folk practice, grave geomancy became prevalent among ordinary people during the Confucian dynasty. The Korean people were so careful in choosing burial sites that they would even delay the funeral until they could find a good burial ground. Indeed, they would go anywhere in order to find an auspicious site. The theory and practice of geomancy is still influential in contemporary East Asian society. According to a 2005 Korea Gallup survey, for example, some 37% of the respondents believed the theory of grave geomancy summarized in a sentence such as "If ancestors are buried in an auspicious site, their descendants will prosper in this world."

Another distinctive aspect of the Confucian funeral concerns a sophisticated practice of mourning garments and mourning periods, which varies depending on the kin relationship between the deceased and the mourner. According to their relationship to the deceased, bereaved family members and relatives wear different mourning garments during the funeral and have different mourning periods. This complicated system of mourning garments and periods is detailed in the manuals of Confucian family rituals, for example, Zhu Xi's *Family Rituals*. Bereaved family members should wear mourning garments from the moment when the body of the deceased is placed in a coffin. Mourning garments are prepared for all the paternal relatives who are related within eight degrees of kinship and for some maternal and other relatives such as sons-in-law. Those mourning garments are made of slightly bleached hemp and consist of four main parts in the case of men's full apparel: a cap, a coat, leggings, and straw shoes. There are commonly five levels of wearing mourning garments determined by the relationship between the deceased and mourners. For example, the sons and firstborn grandsons of the deceased wear the full apparel, while the nephews and cousins of the deceased wear the cap and the leggings but not the coat or the straw shoes. Relatives of the fifth and sixth degrees—first cousins once

removed and second cousins—wear only the cap. The groups of kinsmen belonging to the seventh- and eighth-degree relatives have to attend the funeral but are not required to wear mourning garments. Likewise, the mourning period varies depending on the relationship with the deceased and it is also divided into five kinds, namely, 3 years, 1 year, 9 months, 5 months, and 3 months. The following are some examples. The mourning period for parents' death is 3 years, the longest mourning period. It is 1 year for paternal grandparents' death while it is 5 months for maternal grandparents' death. It is also 1 year for the death of wife, brother (5 months for brother's wife), and sister (if the sister is married, it is 9 months).

Ancestral Rites

Ancestral ritual is the most important of the four Confucian family rituals. Indeed, the other three rituals are basically directed to the practice of ancestral rites, and all four family rituals are to be held in front of the domestic ancestral shrine. After all, the duties of adulthood are oriented to those of marriage, and marriage is understood as a means of producing the ritual heir (the son), the only legitimate person who can continue the tradition of ancestral rites. In general terms, there are four kinds of Confucian ancestral ritual: anniversary-of-death ritual, seasonal ritual, special ritual on holidays like New Year's Day, and gravesite ritual. Confucians commonly perform anniversary-of-death rituals for four ascending generations: parents, grandparents, great-grandparents, and great-great-grandparents. It means that they perform ancestral rites at least eight times a year for anniversary-of-death rituals alone, plus four seasonal rituals, at least two holiday rituals and a gravesite ritual. The key rationale for the practice of these various ancestral rites lies in the expression of reverence and piety toward ancestors (i.e., the root of one's existence), rather than the exercise of belief in the existence of ancestral spirits. Providing regular and frequent opportunities for all the family members to gather together, ancestral rites also have become one of the most significant educational occasions for transmitting family tradition on to the next generation. Through the regular practice of the ritual, participants embody and express their generational status and role, thereby intensifying individual identity and family solidarity as well as assuring the transmission of family tradition.

Chang-Won Park

See also Ancestor Veneration, Japanese; Buddhist Beliefs and Traditions; Christian Beliefs and Traditions

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Coping With the Loss of Loved Ones

To be involved in close relationships inevitably means that one will eventually experience the loss of a loved one. Those who experience such loss are usually surrounded by people in mourning, which is a powerful and stressful emotional state that is rooted in the unconscious psychological reactions to a loss. Grief, although not considered an illness, may nevertheless be so severe as to jeopardize the individual's life. There is no time

frame for grief and, in some cases, it involves subtle factors that can result in self-destructive behavior in the grieving person. Such self-destructive behavior may involve alcohol or drug abuse, malnutrition, disorders related to the neglect of oneself, including the disregard of a prescribed medical regimen or commonsense precautions, and even a seemingly unconscious boredom with life. Successful coping with the loss of a loved one is critical to maintaining the course of social activity.

There are different reactions to the death of a loved one, depending on the age, marital status, social class, ethnicity, and the circumstances of those left behind. The death of a child is a devastating experience for parents. The death of a spouse or a partner involves the loss of a chosen relationship, companion, lover, parent of one's children, friend, and soulmate. Such loss can result in feelings of disorientation, uncertainty, and confusion as one may need to take on roles and tasks previously carried out by the deceased.

Premature Death

Premature death may be incurred in various ways—deliberately by human hands (such as in homicide, suicide, war, and death sentences meted out by the State), as a result of nonhuman creatures (e.g., bacteria and animals), or as a result of accidents. Loved ones who have lost a significant other as a result of suicide are generally called "survivors." Among people who have lost a loved one, survivors of suicide represent the largest group of mental health casualties. The loss of a loved one by suicide is often shocking, painful, and unexpected, and the grief that ensues can be intense, complex, and long term.

In the case of the sudden death of a loved one due to unexpected events, such as natural disasters including earthquakes, large-scale explosions, or disasters in general, there are unique reactions to the event. The "disaster syndrome" consists of a combination of emotional dullness, unresponsiveness to outer stimulation, and inhibition of activity. Individuals who have just experienced a disaster are apt to suffer from at least a transitory sense of worthlessness, and their usual capacity for self-love becomes impaired. In other cases, psychic shock is a common reaction followed by motor retardation, flattening of affect, somnolence, amnesia, and suggestibility. Moreover, a process of "psychic closing off" has been reported in loved ones who lost a dear person in a catastrophic event; this closing off can last from days to even months or can become a more lasting psychic numbing.

Although most people adjust to the trauma surrounding the death of a loved one, and are able to successfully move on to live full and satisfying lives, there are circumstances when adjustment to such loss is difficult. In these cases, acute grief does not resolve (thoughts and memories of the deceased remain accessible but are no longer preoccupying)—the permanence of the loss and the thoughts related to it are neither comprehended nor integrated into attachment-related long-term memory.

Adjustment to the death of a loved one can be complicated by maladaptive attitudes and behaviors. Blame of self or others, fear of the intensity of grief, the prospect of living without the deceased, and a disinclination to engage in activities that were shared with the deceased may impede the resolution of grief. Over the past decade, some investigators studying persons who have persistent symptoms and impairment following bereavement have concluded that there is a syndrome of chronic abnormal grief, also called complicated grief, and recently renamed prolonged grief disorder, a disorder occurring after a loss that causes significant impairments in functioning for at least 6 months. Characterized by either separation distress or cognitive, emotional, and behavioral symptoms such as feelings of confusion or emptiness, it is as if a part of the self has died. There is trouble accepting the loss as real, an inability to trust others, extreme bitterness or anger related to the loss, and avoidance of reminders of the loss. Other features include numbness or absence of emotion; a feeling that life is unfulfilling, empty, and meaningless; and a feeling of being stunned, dazed, or shocked by the loss.

Scholars demonstrate that the symptoms of disordered grief form a syndrome that is distinct from those of depression and anxiety. Characteristic features of such a state include persistent preoccupation with thoughts about the lost person, along with yearning, longing, and an inability to accept the death, distressing intrusive thoughts about the death, and avoidance of reminders of the loss. A major issue is the timely recognition of the transition from normal to abnormal grief as well as what risk factors lead to the emergence of

complicated grief or lead to the development of comorbid disorders such as major depression, anxiety disorders, or somatoform disorders. Recent studies confirm the hypothesis that post-traumatic stress disorder can occur following a natural death. Violent events are time-limited, threaten one's sense of safety, incite fear, and produce hypervigilance to danger.

The loss of a loved one is a permanent ongoing reality that engenders sadness and longing, and produces hypervigilance for the lost person. Images, thoughts, and memories of the deceased, even when intrusive, evoke a bittersweet mix of sadness and yearning. Failure to integrate the information about a violent event may result in post-traumatic stress disorder, while failure to integrate the permanent loss of a loved one may produce complicated grief.

How Children Cope

Children experience grief after the loss of a parent or someone close. Their grief is different from adult grief, as children do not have the same understanding of death. They need to be informed in simple language, with information appropriate for a given age. They should be involved but never obligated to take part in funerals or to observe dead parents or relatives. Children need reassurance and their usual activities and routines should be maintained. Children's knowledge of death varies with age. Under 9 years of age, death is not completely understood as the end of life, but rather it is equated with fear of abandonment or related to magical thinking.

Postvention

Postvention consists of activities that reduce the aftereffects of a traumatic event in the lives of those left behind. Its purpose is to help survivors live longer, more productively, and with less stress. Postventive efforts are not limited to the initial stage of the shock, but rather should be on a day-to-day basis spanning up to a year following the first shock.

Postvention incorporates many tools of psychotherapy, including talk, abreaction, interpretation, reassurance, directions, and even gentle confrontation. The therapist should avoid banal platitudes or the common mistakes often encountered in psychotherapy such as misapplication of the mental examination, for most people who experience grief are not clinically depressed. Common errors that occur are often based on countertransference or a failure to utilize support from within the community. Suicide assessment should always be performed when exploring grief, for there might be fantasies of reunion that fuel suicide wishes. The counselor should play the role of reality tester. Support groups so useful in the healing process can be a helpful source of guidance and understanding as well.

Maurizio Pompili

See also Bereavement, Grief, and Morning; Prolonged Grief Disorder; Sudden Death; Thanatology

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Coroner

The coroner is an elected city or county official and is answerable to the courts. The holder of this office is called upon to undertake medicolegal death investigation, instances involving questionable deaths—those by homicide, suicide, and accident as well as death by natural causes when the decedent had no contact with a physician for a length of time established by a particular jurisdiction. Qualifications for holding the office of coroner vary from one jurisdiction to another, as does the length of time established by local law in which a pertinent death must be reported. The title and duties of coroner have a long history; over time, specific responsibilities have evolved to cover a considerable range of activities.

The information provided by coroner's offices is crucial to both the judicial system and to the recording of public health information. The records and documentation provide vital information about mortality in the United States, information that is used for determining aspects of public health policy as well as serving the need of government, university, and private foundation researchers. In this entry, the history of the title and the duties of coroner are discussed as is the critical role that contemporary media and television crime dramas have had in increasing public interest in this important position.

Origin and History

The word *coroner* originally meant "an officer of the Crown," and the concept dates from medieval times. The edict that formally established the coroner position was Article 20 of the Articles of Eyre September 1194, which stated "In every county of King's realm shall be elected three knights and one clerk, to keep the pleas of the crown." The original Latin is *custos placitorum coronas*, from which the word *coroner* is derived. At the time Hubert Walter, the Chief Justiciar and Archbishop of Canterbury, was temporarily in charge of King Richard the Lion Heart's English kingdom during the king's absence. Archbishop Walter conceived the idea of a death duty, and he created the position of coroner, a person charged with the task of looking into deaths, to make sure that the death duties were paid to the king. When the basic framework of English law came with settlers to the New World, the office and duties of coroner made the crossing as well.

When the English settlers arrived in North America during the 1600s, they brought the coroner system with them. During the next 200 years the coroner became an integral part of death investigation. As the system evolved, change also occurred, especially where the need for enhanced medical knowledge existed. This awareness developed first in England where it was recognized there was a need for medical knowledge to be included in the death investigation. In the mid- to late 1800s, Massachusetts and Maryland passed coroner's acts, which required a physician be present at all death investigations to record any pertinent medical information related to the death.

Death investigation today requires that evidence be collected, coroners conduct an inquest, and valuables and property be collected and safeguarded for return to the rightful owner as opposed to being confiscated as taxes for the Crown.

Influence of the Media

Many people become interested in death investigation through watching television dramas centering on criminal investigations or the coroner's office. Since 2004, a reality show has been shown on the Discovery Health Channel that shows dramatic reenactments of autopsies performed by real-life medical examiner Dr. Jan Garavaglia. Some crime dramas, such as *CSI: Crime Scene Investigation* and *Crossing Jordan,* have had medical examiners as lead characters. The most popular crime drama of this sort appears to have been *Quincy, M.E.* (broadcast from 1976 to 1983), a police drama about a Los Angeles medical examiner who had integrity and a social conscience. Although coroners are not required to solve crimes, Quincy assisted the police detectives in every episode. The show had technical expertise and advisers from the Los Angeles medical examiner's office, and the show was instrumental in bringing attention to many issues and health concerns that had not been addressed in a public forum prior to the origination and airing of this television show. Many coroners and medical examiners report that their reasons for entering the field were prompted in part by watching *Quincy, M.E.* during their youth.

The position of coroner deals with questionable and sudden death, and while some people might describe the occupation as morbid, others understand that coroners are doing a great service to humanity and to their communities. Coroners and their teams put all their resources to the test to find the cause and manner of death in cases of homicide, suicide, accidents, and medically unattended natural deaths. With new crime-solving technologies being developed and implemented, and the increasing number of television dramas focusing attention on this field, many people have become interested in the role of coroner. The work is emotionally challenging and is lacking in glamour, but the work is an essential component of the human experience.

Coroner Qualifications

Jurisdictions vary widely in their qualifications and regulations for coroner. Perhaps the most noticeable difference regarding jurisdictions is that some require a medical examiner system instead of a coroner system. The medical examiner is usually appointed, not elected; may have county, district, or state jurisdiction; and is a licensed physician with training in pathology. The type of system employed, either medical examiner or coroner, may be uniform throughout the state or it may vary from county to county.

There is some debate over whether a physician/medical examiner should conduct death investigations. Given the costs involved in this work, it is not always feasible to justify paying the salary of a physician over a nonphysician in a smaller community. Even when a physician is required, there are some jurisdictions that don't require the physician to be a pathologist. However, only physicians trained in the field of pathology conduct autopsies.

In general, coroners must have a basic understanding of anatomy, physiology, investigative techniques, photography, and medical terminology. The coroner candidate must have excellent written and oral communication skills and be able to supervise pathologists performing autopsies, laboratory technicians, and other office staff. The potential coroner must also have integrity and a good reputation when working with other law enforcement agencies. The person is usually elected for a term of 4 years. In some jurisdictions a coroner may also be the local mortician, sheriff, or county attorney.

Responsibilities of the Coroner

Federal agencies such as the Centers for Disease Control and Prevention depend upon the coroner's office for valuable information and data collected during investigations. The coroner must be notified when a death occurs without any medical attendance; when there is no attending physician; when a physician is unable to state the cause of death; when suicide is suspected, following an injury or an accident; and/or when the death is suspected as a result of a criminal act. In the case of a death by natural causes, many jurisdictions require that the coroner be contacted if a physician had not seen the decedent for a period of 21 to 30 days preceding death.

Most jurisdictions require that the coroner be contacted if a child under the age of 2 years dies suddenly and unexpectedly under circumstances indicating that the death may have been caused by sudden infant death syndrome. In that case, an autopsy is required unless the parent or guardian objects. In most states, the law requires that the death be reported to the coroner, but it is up to the coroner to determine whether or not an investigation will be performed, and if so, what the extent of the investigation will be. An autopsy is required when an individual dies while in the custody of the Department of Corrections. If the results find that the death was unnatural, the coroner will so note this result in the case findings and recommend an inquest.

The Coroner in Action

Duties of the coroner may include notifying next of kin of a death, conducting an investigation, supervising or assisting with an autopsy, meeting with local law enforcement agencies, or testifying at a trial. Acting as an advocate for the deceased, a coroner examines the clues that define the death and is responsible for providing accurate, legally defensible determinations of the causes and circumstances of death, including the identity of the decedent as well as the approximate time of death. Coroners work with the police, forensic pathologists, forensic technicians, attendants, and administrative staff. When a suspicious death is reported, the coroner may personally perform the necessary duties or send investigators to document the scene: to examine the body, interview witnesses, and photograph and sift through the area for clues. Physical evidence, such as the decedent's clothing, is also collected and photographed. Once the investigators are finished at the scene, the body is moved to either a forensic office or mortuary, depending on the jurisdiction. If the cause of death is unknown, the coroner may request an autopsy depending on the circumstances of the death.

Medicolegal death investigation is required by law. Family permission is not usually considered because the law requires that facts and evidence be collected to resolve the issues that might have led to the death. Following a thorough investigation, when sufficient evidence has been gathered, the coroner assigns the cause and manner of death and lists these on the death certificate, referring specifically to the

injury, disease, or toxin that caused the death and whether it was natural or due to accident, suicide, homicide, or undetermined means or circumstances.

Occupational Consequences

Many coroners find death notification to be the most difficult part of the job. Working with the decedent can be much less stressful than having to tell the *living* that a loved one has died. The work of the coroner is far-reaching because each death that is investigated alters the lives of those who have lost a loved one.

Coroners deal with questionable and sudden death; for this reason it is understood that coroners are engaging in essential community, state, and national service. Coroners garner their resources in an attempt to determine the cause and manner of death. The work is not glamorous, but it is necessary and it is required by law.

Kriss A. Kevorkian

See also Causes of Death, Contemporary; Coroner's Jury; Death Certificate; Death Notification Process; Medical Examiner; Mortality Rates, U.S.

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Coroner's Jury

A coroner's jury is a group of citizens who are summoned to serve as members of an inquest to determine the cause of any accidental or suspicious death that occurs within a specific jurisdiction. The coroner's jury may also be called upon to determine the identity of the deceased person. The coroner's office is responsible for leading the inquest and for investigating the circumstances surrounding the cause of death. An inquest is a legal investigative process that varies somewhat by jurisdiction. The structure and role of a coroner's jury also differ between geopolitical boundaries.

History

Although the coroner's jury is viewed by some as a legal dinosaur left over from the medieval England from which the entity first emerged, the coroner's jury has had an important historical role in the system of justice. One recent examination of the origins of the coroner's jury is complicated. Indeed, in what was probably the first historical consideration of the jury, in 1852 it was argued that the jury did not result from any law of government or theory of justice but gradually grew out of institutional forms that were already present. Some similarities between the coroner's jury and other entities can be identified as dating back to Roman times.

The main elements of a jury are that it decides on the effect of evidence, decisions are made under the sanction of a solemn oath, and the jury is distinct from the court. The first and last elements are particularly important because it means that jurors are concerned with making a decision based on the facts rather than on the complexities of law, which is left to the court.

One of the earliest legislative requirements for a coroner's jury is found in the English De Officio Coronatoris, 4 Edw. I. st. 3 in 1276 that required coroners to request people from four, five, or six of the towns neighboring the scene of death appear before the coroner's court so that they could answer questions of fact about the death. Thus, the coroner's jury started out as people who were selected because of their personal knowledge of the case. Indeed, Sara Butler finds cases where jurors were neighbors of the deceased in cases of suicide and shows how their judgment formed the basis for resolution rather than legal presentation. The role of the jury subsequently changed so that 12 members were required to make judgment on the facts and their decision was required to be

unanimous. Note that the requirement for the agreement of 12 jurors meant that there was no specification on the maximum number, but in contemporary legal systems 12 is the most common number of jurors and, in some jurisdictions, a majority decision will suffice.

English and U.S. coroner's juries were once asked for in all inquests. Thus, the juries are associated with a number of historical characters. In the United States in 1882, for example, a coroner's jury found Wyatt Earp, Doc Holiday, Warren Earp, Texas Jack Johnson, and Sherman McMasters guilty of the murder of Frank Stillwell. In England, Lord Lucan, who disappeared the night his nanny was murdered, was charged in absentia by a coroner's jury in 1975.

The Public Interest

Coroner's juries are not merely a legal historical process; they also play a contemporary role in almost all countries that have a legal system involving juries. A coroner's jury can be used for all inquests, but it is more common for their use to be limited. Although coroners can call upon a jury for any inquest in which they are involved, in most instances a coroner's jury is convened because it is believed there is something unique in the circumstances thought to have led to the death. Thus, any investigation into the cause leading to the death would benefit from the testimony and opinions of learned people within the community.

Legislation requires that a coroner's jury be used in cases that are of public interest. This includes death that occurs when the deceased is detained by the state, such as when imprisoned or in police custody, to ensure against the arbitrary use and abuse of the tremendous power of the state. Furthermore, a coroner's jury may be mandatory in cases that have implications for public health, safety, and security, especially when aspects of strategic national importance are implicated. Examples include deaths on the railway, accidents on ships at sea, and deaths involving civil and military aircraft.

Inquest and Cause of Death

A coroner's jury usually has a number of predefined decisions that they can make, which are termed *rulings*. There are five main causes of death categories: (1) death by misadventure, (2) accidental, (3) natural, (4) suspicious death, and (5) so little evidence exists that the cause of death remains undetermined. Some jurisdictions have rulings that are more specific, including, for example, death by attempted or self-induced abortion and death as a result of another's self-defense.

An inquest with a coroner's jury is similar to a Grand Jury, which is like a pretrial that is held to determine if a court case should be initiated. Consequently, a coroner can recommend a named individual be mandated to trial. While such a recommendation may not be legally binding, it would be unusual for the rest of the legal system to ignore the rulings that emerge from an inquest.

The criminal trial—with a judge, prosecution, defense, and jury—is the archetypal legal process for making rulings in much of the West and because of this, coroners are often seen as holding too much power. Even if a coroner cannot commit someone to prison, his or her role in determining the manner of death is important for the family and friends of the deceased, and this can have implications for the payment of life insurance as well. In cases of death that are of public interest, the decision of the coroner can affect how public institutions respond to that death and their ability to prevent similar incidents in the future. A coroner's jury can provide an additional element of legitimacy to the legal process of the inquest. Nevertheless, juries are not without problems because they are often viewed as increasing the cost of the legal process. Some analysts also suggest that juries are often unable to adequately comprehend complex cases. Consequently, coroner's juries are likely to remain a viable entity, but only for those cases that are likely to receive a considerable amount of public attention.

Peter Branney

See also, Causes of Death, Contemporary; Causes of Death, Historical; Coroner; Medical Examiner

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Cosmetic Restoration

Cosmetic restoration is the treatment and preparation of the dead body prior to its disposition. Today cosmetic restoration is a series of sophisticated procedures that utilizes technology, prosthetics, and makeup. Taking place at the same time as embalming, cosmetic restoration is usually concentrated around the most visible areas of the body, such as the face, throat, and hands. It is widely considered to be a significant part of the funerary ritual process, and it is related to analyses of the denial of death.

Cosmetic restoration is the practice(s) of making the body appear lifelike and natural; some would even go so far as to say making it look alive. It is typically undertaken when a body is to be viewed by bereaved survivors. Restoration normally involves facial and bodily reconstruction, the application of cosmetics, and dressing of the body. The actual activities that surround preparing the body after death are culturally specific, including when the activities are performed and by whom.

Currently, cosmetic restoration is most popular in North America and is undertaken by a mortician once the body is in the possession of a funeral director. Overall, Christians neither overtly support nor object to it, whereas Orthodox Jewish and Muslim religions consider it a desecration of the dead body and therefore prohibit it. One of the motivating factors for cosmetic restoration to be undertaken is due to the physical, bodily changes that take place once a person has died. In places and religions where it is customary to cremate the body, such as Sikh and Hindu communities, or where it is not usual to view the body, there is little need for the body to be restored, and therefore it is not common practice. In the United Kingdom, for example, where cremation accounts for over two thirds of all dispositions, and the deceased is not typically available for public viewing before or during the funeral, it is unusual for the body to be cosmetically restored. In the United States, where public viewings of the deceased are much more popular, it is much more common to attend to the body in some way. Thus, the act of cosmetic restoration needs to be understood as intricately associated with cultural customs surrounding the handling and public display of the body after death.

The process of restoring the body is often promoted and marketed as the option to create a lasting and lifelike "memory picture" of the deceased. This lifelike impression has strong associations with postmortem photography, which was particularly popular in the late 18th and early 19th centuries, whereby the dead body was arranged to appear as if asleep.

The actual process of cosmetic restoration is unique to the deceased person and the manner of his or her death. Once a person has died and the heart has stopped pumping blood to organs, gravity causes the blood to sink to the lowest part of the body. For example, if the body is face up then blood collects in the back and buttocks. This is accompanied by a loss of muscle tone, the result of which is discoloring, and parts of the body beginning to sag, with eyes in particular prone to sinking into the skull. These early stages of putrefaction can be extremely distressing for the recently bereaved to witness, and this is one of the main reasons why funeral directors suggest cosmetic restoration prior to a viewing.

Once a body has been released for disposal and the next of kin have specified their wish for the body to be prepared for viewing, it is cleansed. After washing, the first major task involves "setting the features," an expression that refers to the arrangement of the facial expression. Morticians normally ask for a recent photograph of the deceased person, preferably in good health, to try to mimic their natural living appearance as closely as possible.

There are several components to setting the features, which depend on the age and gender of the deceased and the cause of death. In the initial stages, it may involve massaging the face and parts of the body to break down rigor mortis in the muscles. If the deceased had been involved in an accident or had had surgery, including a postmortem,

it may also be necessary to undertake some element of bodily reconstruction. Wax, plaster of paris, and adhesive can be used to reconstruct parts of the body, with prosthetics widely available to rebuild features such as the nose, lips, eyes, ears, and limbs. If limbs were severed and still obtainable, they can be sewn back on, including the head. If not, clothing can be used to disguise missing body parts.

After this, children's and babies' faces are routinely covered in massage cream to give them a "dewy" glow; for older people, rough skin is sandpapered to present a smoother, unblemished complexion. On all bodies, the throat and cheeks are packed with cotton to prevent leakage and appear fuller. In adults, lips are stitched, wired or glued together to prevent gravity from pulling the mouth open. For children, the mouth is usually positioned to be slightly ajar, a look considered to be more natural for younger people. Eye caps are inserted to keep eyeballs in the correct position and the eyelids shut. This has been interpreted as a contemporary form of keeping the eyelids shut using pennies (which, as Christine Quigley has stated, is contrary to the popular belief that pennies were primarily used for payment in the afterlife). Hair is washed, cut and styled, and false hair and wigs are used in cases where the deceased had lost their hair, for example, through treatment for cancer. Facial hair is plucked and trimmed, and men are shaved. Moisturizer or massage cream is then applied to stop skin from drying out. Orifices such as the ears and nose are packed with cotton to prevent any seepage.

After setting the face, cosmetics are applied. Different shades of makeup are used to add depth and warmth, so it is common for red and pink makeup to be used in areas where blood would normally be found close to the surface of the face (such as in the cheeks and lips). Brown hues are added around the eyes to make these areas of thinner skin appear more luminous and lifelike. Eyes are then finished with eyeliner and mascara if necessary. Often applied using an airbrush, bleach or very thick makeup, similar to the consistency of face-paint, can be applied to minimize or hide bruises, cuts, and discoloring. This is particularly important if the deceased died as the result of head injuries or had a postmortem that involved incisions to the face, throat, or skull. Fingernails are cut and painted and fingers glued together if required. The deceased is then dressed in (preferably his or her own) clothes and jewelry and transferred to the coffin. The hands and head of the deceased are positioned to create a natural appearance, reminiscent of a sleeping posture.

The purpose of cosmetic restoration is to be invisible. That is, the aim is to create such a convincing, natural appearance that bereaved visitors would not be immediately aware that the body had been attended to, or even that the person had died. Problems with cosmetic restoration can arise because the person who tends to the body did not know the deceased prior to his or her death and therefore structures the facial features or applies makeup in unfamiliar ways. Seeing the deceased looking "unnatural"—that is, not how they looked when alive—may be deeply upsetting for bereaved people and is therefore something that funeral directors are keen to avoid.

In an effort to prevent this, funeral directors must assure clients of their ability to tend to the body of the deceased and must adhere to particular standards of bodily preparation. It is becoming increasingly common for those involved in cosmetic restoration of the dead body to undertake formal training and qualifications. In the United States, for example, this can be done through the various mortuary science programs offered by the National Funeral Directors Association. As a part of the overall professionalization of the funeral industry, cosmetic restoration is also increasingly governed by professional codes of practice. In the United States one of these is the National Funeral Directors Association's Code of Professional Conduct; in the United Kingdom it is the National Association of Funeral Directors' Code of Practice. These codes, however, are voluntary rather than obligatory agreements and are made on a case-by-case basis between the member organization and the funeral directing firm.

Critics of the cosmetic restoration of the dead body have argued that these practices transform the deceased's body into an object and commodity that "solves" the process of bodily decomposition. The process of decay, they argue, symbolizes a threat to the loss of the self and is a reminder of our mortal condition. As a result, it is something that must be concealed. For critics, cosmetic restoration not only encourages unrealistic expectations of the appearance of a dead body, it also contributes

to an overall societal denial of death. By restoring the dead body, cosmetology can therefore be seen as a barrier to accepting the physical, and embodied, reality of death.

Now an enormous industry, cosmetic restoration has also been criticized for offering a very lucrative source of income for those involved in the trade, and consequently may not always be offered and undertaken in the absolute best interests of the bereaved. There is further concern that bereaved people are vulnerable, and therefore susceptible, to being encouraged to spend a lot of money after the death of a loved one, and that cosmetic restoration is subsequently another possible source of exploitation.

In contrast, supporters of cosmetic restoration of the dead body have argued that instead of seeing restoration as being about a denial of death, rather it could be seen as part of the process of confirming the death of an individual, and as a ritual starting point for the deceased in their transition to their new identity of "the dead." Proponents of cosmetic restoration have also argued that it may assist the bereaved in coming to terms with their loss, by enabling them to view the natural-looking lifelike body and have a lasting image of the deceased. These two ways of interpreting cosmetic restoration—on the one hand, going to lengths to avoid the physical outcome of death and decay, and, on the other hand, offering the bereaved a comforting lasting image of the deceased—creates something of a tension. The task of funeral directors and those who work in the aftercare industry is to recognize and accommodate these two potentially conflicting perceptions and expectations of cosmetic restoration. As the demand for cosmetic restoration in the 21st century shows no sign of abating, the challenge for the future will be to provide restoration services that bereaved people request and desire, but to do so in the way that does not cause upset or exploitation.

Kate Woodthorpe

See also Decomposition; Denial of Death; Embalming; Funeral Director; Wakes and Visitation

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Counseling, Grief, and Bereavement

See Grief and Bereavement Counseling

Cremation

Cremation is the process of burning the human corpse until only some bone fragments and ashes remain, material often described in American English by the neologism *cremains*. Cremation possesses two trajectories within human cultures, one that is long-standing and of ancient origin and the other of modern invention. The former is reflected in archaeological findings from the New Stone Age of some 8,000 years ago in China and 6,000 years ago in Britain as well as in ancient Greece where they pass into Bronze Age and Iron Age practice only to be replaced by burial by about the 5th century B.C.E. Ancient customs of cremation on the Indian subcontinent are still familiar in Hinduism, Buddhism, and Sikhism, which retain cremation as their main funerary rite of human disposal. The modern invention of cremation, by contrast, began in the later 19th century in Europe as a result of scientific modernization aimed at social welfare on the one hand and ideological opposition to traditional Christianity on the other. Although this entry focuses on the modern resurgence of cremation, it also sketches aspects of these ancient traditions to stress that cremation serves as a vehicle for a variety of political, economic, and social values as well as specifically ideological or religious beliefs.

Early in the 20th century the French anthropologist Robert Hertz made the important point that cremation itself is seldom a single rite of burning the corpse but often involves a secondary

process dealing with the ashes as part of the reorganization of a society after someone's death. The dead person is often given a new identity, perhaps as ancestor, while the living come to terms with their own bereavement. The ashes may be buried, placed in running water, or even ingested.

Ancient Continuities

Underlying the ancient roots of cremation in India is the idea of cremation both as a kind of sacrifice to the gods and as a vehicle by which the lifeforce or spirit is released from the body that it has vitalized during its lifetime. In traditional Hinduism, Buddhism, and Sikhism, that spirit is believed to have a life of its own in the ongoing round of existence or *samsara* by which it comes to inhabit a series of life forms prior to human birth and after bodily death. The notion of *karma* controls this ongoing passage of the lifeforce in terms of a scheme of cause and effect grounded in a moral code of right behavior. Life lived according to religious-social laws that are grounded in the human affinity for reciprocity conduces to an accumulation of positive moral power or merit and will lead to a better future existence, whereas a negative valuation has the opposite effect.

This ideology links birth and death and makes sense of cremation as part of a wider processing of the self in India-derived religious schemes, including the sense of cremation as a final gift made to the gods, the last act of devotion in this present existence. The traditional Indian cremation pyre could, therefore, be seen as a form of altar of fire sacrifice. The equally traditional custom of the eldest son cracking the deceased parent's skull during the process of cremation, similarly, sets free the lifeforce for its transmigration prior to future embodiment.

Banaras, often called Varanasi, is a distinctively holy city whose symbolic place in Indian thought includes the view that to die and be cremated there is to end the cycle of reincarnation. To have one's ashes placed in the River Ganges is, also, a highly desired goal and exemplifies Hertz's argument of the double nature of cremation processes. The Christian world had no such ideology of samsara and karma by means of which to interpret cremation, its own basis for understanding death rites being dependent upon burial in imitation of the death and burial of Jesus Christ and in hope of a resurrection rooted in the belief in his resurrection from the dead.

Modern Cremation

In Europe, cremation had been common in much of the western Roman Empire for several centuries before the Christian Era, but this changed during the 2nd century for a variety of reasons, including the fact that the Emperor Constantine (274–337 C.E.), Christian convert that he was, forbade cremation. This led to a millennium and a half era of burial tradition throughout expanding Christendom.

Although some interest in cremation was shown in France in the 17th century, little came of it and it was not until after the 1850s that the topic began to be widely debated. Such innovation met with a variety of responses from Christian churches that had, very largely, come to assume a dominant role in funeral provision of burial. The Eastern Orthodox tradition remained staunchly opposed into the 21st century on the basis that Christ had been buried and resurrected and was the model for all Christian believers.

Most Protestant churches came to accept cremation, but this was not the case with the Roman Catholic Church. In the 1886 Declaration *De Humana Corpora Cremandi*—pertaining to the cremation of human bodies—the Church opposed anticlerical and secular groups, especially the Freemasons. The Church specifically disapproved of societies that promoted the practice of cremation of human bodies. This position was further reinforced by a Canon Law of 1917 that removed the right of a church funeral to those who chose cremation. Given the importance of Catholicism in Italy this was one reason why, despite some Italians being innovators and leaders in cremation ideology, it did not become a widely practiced form of funeral.

It was not until the 1963–1964 statement *De Cadaverum Cremationе*—concerning the cremation of corpses—and a new church law of 1983 that the Catholic Church allowed for cremation of its faithful members. Nevertheless it took a considerable period for established burial custom and opposition to cremation to decline in traditional Catholic countries in contrast with traditional Protestant countries where relatively little sustained opposition to cremation occurred.

This difference is evident in the data presented in Table 1. These data represent the period shortly after the change of outlook of the Catholic Church. Percentages are also included for the United States

Table 1 Cremations in Selected Countries by Percentage of All Funerals

	1968	*1990*	*2000*
Italy	0.17	1.0	5.28
Ireland	Not available	2.52	5.5
Spain	Not available	2.83	13.69
USA	4.35	17.2	25.39
Sweden	36.3	61.1	69.54
UK	51.22	69.81	71.50

Source: Davies, D. J., & Mates, L. H. (Eds.). (2005). *Encyclopedia of cremation* (pp. 449, 453, 455). Basingstoke, UK: Ashgate.

as well to reveal a distinctive yet complex profile that reflects both the Catholic inheritance and the Jewish influence that tended against cremation, and because the data hint at the extensive rural nature of many American towns where burial grounds were well established as community identity points and where land was far less a problem than in many highly populated cities.

Cremation can be taken as an index of traditional Catholic and Protestant cultural histories as well as one potential marker of secularization. Early 21st-century Europe has witnessed a relatively rapid rise in cremation rates in otherwise traditional Catholic countries at a time when strict adherence to Church rule and doctrine has declined. By 2005 the cremation rate in Spain was 19%, France 25%, and Portugal 36%. In the United States it was approximately 32%.

National Differences

The Western country that came to lead the field in modern cremation was Great Britain, especially England and Wales, fostered by The Cremation Society of Great Britain. The statistics shown in Table 2 indicate the development of cremation in Britain from the time that cremation numbers can be taken as a percentage of all deaths. The small numbers recorded during the late 19th century represented higher levels of the socioeconomic profile of Britain, whereas as the 20th century progressed, this funeral form became more widely democratized with 1968 being the year when cremation became the dominant mode across the whole of the United Kingdom. Once cremation reached approximately 70% to 72%, it leveled out, leaving approximately one quarter to one third of the population indicating a preference for burial.

Ashes

Modern cremation takes from 1 to 2 hours to reduce a human corpse to ash and bone fragments. The coffined body is usually placed in a cremation chamber preheated by gas, electricity, or oil. The coffin burns and then the body becomes dehydrated and contributes to its own combustion as its fat and other components ignite in temperatures of around 700 °C to 850 °C. Modern techniques control the rise and fall of temperatures to maintain optimum burning conditions and, in many contexts, to reduce the level of visible dark smoke coming from crematoria chimneys. Increasingly, much effort is made to include filters that may also control or reduce the output of noxious gases.

After cremation the remains are raked from the oven itself, often with considerable care to keep one person's remains distinct from the preceding cremation. These are often then placed in a machine called a *cremulator* that grinds them, especially bone fragments, into a more uniform consistency, before placing them in some appropriate container to return to the relatives. Ashes are convenient for transporting the dead as today in parts of America

Table 2 Cremation Rates in the United Kingdom by Percentage of All Funerals

1887	*1907*	*1927*	*1937*	*1947*	*1957*	*1967*	*1977*	*1987*	*1997*
0.02	0.12	0.59	2.44	10.48	28.36	48.58	63.62	69.05	72.02

Source: Davies, D. J., & Mates, L. H. (Eds.). (2005). *Encyclopedia of cremation* (pp. 435, 438, 442, 444, 446–449, 451, 453, 455). Basingstoke, UK: Ashgate.

and Europe when, for example, people move away in retirement but are returned to their family hometown after death and cremation.

The final location of ashes differs widely. Ancient societies often placed them in urns in graves. Traditional Indian custom prefers running water as part of its wider ideology of the cycle of human elements. Some eminent Buddhist remains are located in stupas, which become a focus of reverence. Modern Christian cultures preferred the burial of remains to retain the idiom of traditional Christian burial as symbolic of the burial of Christ in anticipation of the resurrection. Some have encouraged the use of columbaria with niche walls for ash urns or lawns and other gardens of remembrance. Sometimes this act is ritualized, but often it is a utilitarian event. Rare innovations include an ash fountain in Budapest where, in a lawned environment, an electrically driven device spins and scatters remains into upward-shooting water fountains in an aesthetically attractive fashion. From the later 20th century, British families increasingly placed ashes in sites of personal significance, often echoing aspects of the deceased's life. Groups in the 21st century have made it possible to have ashes distributed through fireworks, sent into space, or even built into a kind of coral reef.

Crematorium

Modern cremation has been contained within buildings whose design expresses symbolic aspects of life, death, and destiny. The crematorium is one of the few innovative structures of the late 19th and 20th centuries. Because churches and graveyards had long been associated with funerals, crematorium design initially took an ecclesial form; later developments sought novel schemes to express the depth of human life and grief while also affording a sense of hope and life's value. The oven itself has regularly been set within the work area of a utilitarian type quite separate from the main hall where the funeral ceremony occurs. A major design involves the actual movement of the coffin from that public ritual space into the more private zone of technical disposal. That zone is often divided between a more aesthetically symbolic "charging area," where the coffin enters the oven, and a work-like area at the other end, where the ashes are removed, ground up, and passed on into some more formal office or bureaucratic domain. This plan involves a kind of distinction into more and less "sacred" spaces.

'The one design feature that has often occasioned critical comment is the way the coffin is removed from the main ceremonies hall or chapel into the charging zone. This marks the moment when, for the great majority of modern cremation rites, the relatives and friends have their final contact with the coffined body. Some crematoria adopted a descending mechanism so that the moment of parting is highly reminiscent of burial. In these cases the cremators are often also at a lower level. Others employ curtains that are drawn between the coffin and the funeral party with the coffin removed after people leave the hall; yet others, albeit a very small proportion, have used a kind of conveyor belt or a roller system by which the coffin may be transported through a hole in the wall. Finally, some let the coffin remain visible while the people physically leave the hall. There are advantages and disadvantages to all of these methods. One common criticism has referred to the sense of being "processed" or to the impersonal nature of cremation rites. This is understandable when the established culture of a society has involved burial, which is more labor intensive and directly in touch with earthy elements. Some crematoria have been designed so that people enter and leave the main hall by different doors, thereby easily giving the sense of being processed or managed in contrast with many traditional sacred spaces that are, normatively, entered and left by the same route. In some societies the actual crematorium building is extremely functional and not used as a place for ceremony; instead the rites occur in an actual church or funeral home with the coffin being sent for cremation as a separate and pragmatic event.

The design of crematoria also raises the issue of religious or nonreligious symbolism. Some of the Freemasonic cremation "temples" in Italy, as at Turin for example, bear the architectural features of classical antiquity, including Egyptian pyramid-like elements, rather than any Christian marks. Such explicitly non- or anti-Christian features, along with the rites conducted in them, were a sure challenge to established Christian orthodoxy whose identity is often manifest through church buildings

and their associated rites. As the 20th century progressed, a divergence occurred between crematoria that were built to resemble or which were developed from cemetery chapels, with all the appropriate use of religious symbolism such as crosses and stained glass windows, and those that struck a nonreligious note that made the building usable by people from any or no religious tradition. Rarely, as at the very large crematorium at Seoul in Korea, different ceremonies rooms are provided for different religious and cultural traditions. In many late-20th-century crematoria, movable symbols enable a wide variety of groups to have a symbolic environment appropriate to themselves. Much attention is frequently given to the landscape and gardens surrounding crematoria to capitalize on the power of vegetation and running water to frame the emotional lives of those attending them.

The transient nature of cremation has led to various forms of memorialization of the dead at crematoria, whether in inscriptions, plaques, or in a formal Book of Remembrance held in a special room. All of these allow people to revisit a crematorium and engage in some memorial activity focused on some representation of the departed person. Some of these books are costly and echo established forms of book-binding and calligraphy. With the advent of the Internet, many companies and cremation authorities have also provided online forms of memorial.

Legalities

One of the most frequent objections raised against cremation in its earliest decades was the worry that it would hide murder, making it impossible to gain forensic evidence from a cremated body, unlike the situation where a buried body might be exhumed. To counter this issue, cremation associations, societies, and managers of premises sought legal safeguard through the implementation of appropriate medical certification of the death.

Cremation's Negative Image

Cremation has been used as a means of disposing of the dead in circumstances of war and pestilence. Some ancient Greek sources tell of cremating the large number of people killed in battles or when individuals have died far from home. One 20th-century example is that of epidemic deaths having many corpses treated by emergency cremation. The use of cremation in the Nazi Holocaust, as also in the burning of those denounced as heretics in several traditions, has imparted a radically negative value to fire in relation to human death. This echoed the image of fire as the punishing element of hell in some traditional Christian ideas of the afterlife.

Pets and Objects

It is not only people who are cremated. While the mass incineration of animals has been well-known in cases of disease, from the later decades of the 20th century it also became possible to have pets cremated at specially designated pet crematoria in various Western societies. The city of Tokyo, Japan, even accommodates a traveling crematorium to visit a family's home to deal with their dead pet. In this, the honorary-human status accorded to some pets becomes particularly obvious. Japanese custom also has a provision for the burning of domestic objects, not least, chopsticks, when at the end of their useful life. This reminder of how humans treat valued objects in highly symbolic ways brings them into a wider grammar of discourse of dead bodies.

Douglas J. Davies

See also Buddhist Beliefs and Traditions; Christian Beliefs and Traditions; Columbarium; Cremation Movements; Hindu Beliefs and Traditions

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Cremation Movements

The emergence of modern cremation in the 19th century, and its flourishing in the 20th, heralded a distinctive element of social change in industrial societies. This change did not occur by accident or by any gradual shift from preexisting burial traditions, but through the campaigning of special voluntary interest groups, which possessed a variety of motivations toward social reform. The shift to cremation was strongly advocated or imposed by political agencies of state. This entry differentiates between these two categories of voluntary association and ideological fraternity on the one hand, and political agencies on the other, before concluding with an account of national and global organizations and the effect of their publications on the development of cremation.

Types of Movement

Voluntary associations typify what first comes to mind as cremation movements: groups established to promote the modern practice of burning the human corpse until ash and bone fragments remain. They have, probably, been the least known, yet ultimately, the most significant influencers of cremation practice. They came into being specifically to promote cremation through debate, conferences, journals, and political lobbying for funeral law reform. Many countries have had or still possess such cremation societies and associations.

By contrast, the ideological fraternity aspect of this type refers to Freemasonry, especially in Italy in the later 19th century, when its more general ideological-philosophical policies focused on cremation as part of an anticlerical movement. Outside this context many Masons were Christian and not hostile to religion, unlike many in the dynamic political world of mid- and late 19th-century Italy. There, Masons triggered a powerful ecclesiastical response from the Roman Catholic Church, which opposed cremation for nearly a century.

The second type of cremation movement accounts for large-scale political institutions of state, typified by China, Japan, the former USSR, and the short-lived Nazi regime of the Third Reich. Each, for quite different reasons, either encouraged or enforced cremation.

Voluntary Associations

Voluntary associations have been the most influential of all cremation movements because they identified underlying needs of particular groups in society that became increasingly appreciated and widely accepted by others. Such associations have depended for their birth upon the far-sightedness of individuals who gathered around themselves like-minded people capable of creating intelligible and persuasive programs of activity. This mix of allies has often involved both charismatic and bureaucratically informed individuals possessing extensive social and cultural influence derived from their ordinary professional, commercial, and cultural lives. In the 19th century this typically involved medical and other scientific workers, allied with social and welfare reformers, as well as literary, artistic, or philosophical thinkers. The following selected individuals, and the groups they patronized, could be much expanded for many countries.

Ferdinando Coletti (1819–1881) was an influential Italian academic, professor at Padua's ancient university, medical scientist, and regional politician; he argued the case for modern cremation as a replacement for burial from as early as 1857. Indeed Italy—whose integrated Kingdom was founded in 1861—became a focus for much cremation debate and practical activity, especially in the 1870s. The first western cremation temple was built in Milan to cremate the industrialist Alberto Keller in 1876. The same year also saw the United States gaining its initial cremation facility. Many cremation societies were established across the world from the 1870s, including those of Great Britain and Holland in 1874, Milan in 1875, France 1880, Denmark 1881, Turin 1883, and Vienna 1885. Medical doctors, scientists, and

literary and philosophically minded individuals often spearheaded these societies and pressed for the legalization of cremation in their respective countries, as well as arguing for the building of crematorium facilities. In Australia, for example, Dr. James Neild, an academic doctor in Melbourne, presented a paper titled "On the Advantages of Burning the Dead" to the Royal Society of Victoria in 1873.

The desire for funeral reform was often prompted by the desire for improved social hygiene and welfare provisions in towns and cities that had grown dramatically as a result of industrialization. Sometimes cremation became a cause and focal point for workers' groups as in Austria's Labor Cremation Society Die Flamme, which was formed in 1904 and had a social-democratic outlook and opposed the Catholic Church's position.

Ideologies: Freemasons, Catholics, and Theosophists

Freemasonry, which in Catholic countries often took an anticlerical and secular standpoint, was particularly influential upon the growth of cremation in Italy and some other European countries. To have a secular ideology is one thing, but to engage in a clearly secular ritual in newly architected and deeply symbolic buildings is another, and that is just what happened in many of the later 19th-century Italian "cremation temples" such as that of Rome, built in 1883, or Turin in 1888. In 1874, a key Italian Freemasonic group undertook to promote cremation throughout the newly united country, led by the medical doctor Gaetano Pini (1846–1887), who had also fought alongside Garibaldi. Pini's perspective was one of secular reform, hygiene, and social welfare. His leadership, and the zeal of many other Italian leaders, meant that by 1886 there were some 36 active cremation associations and 14 operating crematoria in Italy. The Catholic response essentially banned cremation for Catholics from 1886 until 1964. The influence of Masonry and the Italian background is also evident in the pioneering cremation work of José Penna, who organized the first cremation in Argentina in 1884. The person involved had died of yellow fever; indeed, Penna had the issue of contagious diseases and epidemics as a long-term medical commitment. This example shows the complexity of motivation over cremation given Penna's medical-social concerns.

Other groups encouraging cremation included Theosophy, established in 1875 in New York by Madam Blavatsky and Colonel H. S. Olcott. It sought to integrate what it believed to be ancient teachings of divine wisdom with the new discoveries of evolution. With deep interests in India—it moved its headquarters to Bombay in 1907—it is not surprising that some Theosophists found the new cremation debates and the possibility of practicing cremation appealing. Theosophical groups, both in the United States and in Australia, were influential advocates of cremation. In 1876 it was Olcott who organized the funeral ceremony for the Freemason Baron de Palm with a ceremony held at a New York Masonic Hall followed by cremation at the medical doctor Julius LeMoyne's cremation facility. This first modern American cremation classically integrates medical-scientific motives with Freemasonic and Theosophist ideals.

National Societies

In Great Britain, the Cremation Society was founded in 1874 by Sir Henry Thompson, who had been influenced by a visit to Vienna's World Fair in 1873 where he saw Coletti's model cremator. Thompson, himself surgeon to Queen Victoria, gathered a group of like-minded friends together in London, and in January 1874 they made a declaration aimed at replacing burial by some appropriate means of reducing the body to its constituent elements by some means "innocuous" to the living. For the time being they considered cremation to be the most appropriate alternative.

The Cremation Society of Great Britain that followed that declaration had a colorful history, building its first crematorium at Woking, where the first cremation took place in 1885. This was before cremation had actually been given formal legislation by any act of Parliament, which did not take place in Britain until 1902. In 1884, however, a most unusual event in Wales had led to a judicial decision that cremation was not unlawful as long as its performance did not disturb the public peace. This decision by James Fitzjames Stephen, a man of wide knowledge and experience, including a period in India, was occasioned by the act of one William Price who, at the age of 84, decided to

cremate an infant son whom he had named *Iesu Grist,* the Welsh for Jesus Christ. The burning had been stopped during public protest, and Price was arrested. Judge Stephen's ruling on this case involved a long analysis of the history of cremation in antiquity, and his basic analysis hung on the idea that cremation accomplished rapidly just what burial did more slowly, namely, the dissolution of the corpse. He was not troubled by any Christian theological concern over burial and resurrection, an issue that many other contemporaries might have advanced as an objection to cremation. Among those who had influenced this judge was Sir Henry Maine, the Master of Trinity Hall in Cambridge. His particular case illustrates the way in which cremation in one particular country emerged as a result of a number of determined and influential characters who adopted ideas from other European contexts and sought to render them practical in their own society. It shows how innovation encountered opposition but also benefited from the serendipity of idiosyncratic events and persons.

In the United States the figure of Francis Julius Lemoyne of Washington, Pennsylvania (1798–1879), dominates the emergence of modern cremation. He was medically trained but also much involved in political activity and social reform, including antislavery activity. He built a cremator on his own property in 1876 and experimented with the cremation of a sheep. Many involved in the cremation movement in the United States were drawn from the medical world, social welfare, and sanitation, often including individuals with more open religious views derived from such groups as the Unitarians, Universalists, Episcopalians, or the Theosophists. This early phase of ideologically driven cremation movements, also inspired by another powerful figure, Michigan doctor Hugo Erichsen, then seemed to pass into a more business-oriented commercializing of cremation in the United States.

In Malaya the emergence of modern cremation was influenced by Wu Lien-Teh, a Cambridge-educated doctor whose interest had been galvanized in China when he had been chief medical officer of the Manchurian city of Harbin, where over 2,000 people had died from pneumonic plague in 1911. Only after special permission was received from the Emperor of China were the corpses burned in mass outdoor piles. Since that time many contemporary societies have also had to plan for mass cremation in anticipation of military warfare and catastrophic levels of death.

Political Movements

Japan possesses a complex funerary history involving ideological preferences allied with different views of Buddhist preference among elite and popular groups. From a long tradition of burial, through intense debates from the 17th to the 20th century, Japan came to near-universally adopt the practice of cremation by the late 20th century. China also experienced shifts from traditional forms of burial to cremation and back to burial all before the 17th century. It fell to the People's Republic of China in 1956 to establish a formal proposal for cremation to save land and excessive funerary expenses. The espousal of cremation by Communist Party officials has been described as among the first of the revolutionary social transformations. When the country's premier, Zhou Enlai, died in 1976, he was cremated and his remains were scattered throughout the land. Many new crematoria, laws, and qualifications for operatives ensued. In China, by 2002, just over half of those who died were cremated.

Though cremation had been discussed in Russia in the 1880s, it was not until after the 1917 Russian Revolution that the state legalized cremation in 1918, in the face of strong opposition by the Russian Orthodox Church. In 1927, a formal state Society for the Dissemination of the Idea of Cremation was established, but cremation did not gain much popular acceptance, and only then in the cities, in the 1980s after large-scale urbanization had taken place. Despite the demise of the USSR and the resurgence of Orthodoxy, cremation remained a viable economic option for poorer people even if the new rich preferred burial.

Perhaps the best-known formal "state" program of cremation was that of the Nazi Third Reich. In 1934 regional legislative variations were overridden when cremation and burial were made equal in law. Previously some German regions had relatively high cremation rates in Protestant areas. Then, during World War II, cremating ovens were developed for use in concentration camps and were used to burn vast numbers of corpses. This

"corpse incineration" has sometimes been differentiated from cremation because of its radical utilitarian and inhuman nature; it reduced the popularity of ordinary cremation in Germany after the war.

These examples highlight the symbolic role of fire, enhancing its preexisting mythological-theological role in images of hell and afterlife punishment and revealing one aspect of negative public opinion that cremation societies and the cremation movement had to overcome in their campaigns to win over legislators and public opinion.

Global Aspects: Conventions, Conferences, and Journals

Engagement with popular opinion and the established views of legislators and ecclesiastical authorities had been the major task of individuals forming and leading cremation movements in the 19th century. That century had, however, witnessed remarkable developments both in innovation and international industrial trade and commerce, often aligned with an increased sense of national identity. Gatherings, such as the International Technological (World) Exposition held in 1867 in Paris or Vienna's World Fair of 1873, as well as medical conferences often raised issues over lifestyles as well as matters of medical hygiene, social welfare, and town planning. This increasingly global ethos facilitated international gatherings of existing cremation societies and of people wishing to establish them, for example, in Brussels (1910), Dresden (1911), and Prague (1936). An American gathering in 1913 also heralded a new Cremation Society of America that, as it happened, was supported more by funeral professionals than by social reformers as such. The Prague event, however, proposed a major gathering for London in 1937, the outcome of which was the establishment of an International Cremation Federation. By the following year no fewer than 18 countries were financially supporting this federation, whose development was much hindered by World War II. It resurged, however, and at the outset of the 21st century, it provides a major global forum for encouraging national societies and for developing knowledge of technical and ethical aspects of cremation, not least through periodic conferences. Some national societies also hold their own conferences, with the Cremation Society of Great Britain's annual event being particularly popular with international delegates. It also publishes the highly informative journal *Pharos International*, which began publication in 1934. One earlier example of publication was that of the Austrian Cremation Society whose journal, appropriately titled *Phoenix*, dates from 1887. During the 19th century, in the intellectually intense years of debating cremation across the world, certain key books and articles catalyzed and informed people. Sir Henry Thompson's 1874 essay "The Treatment of the Body After Death," in the January edition of the United Kingdom's *The Contemporary Review*, was matched by Dr. Hugo Erichsen's *Cremation of the Dead* in 1887 in the United States. One early consideration of cremation was that of Sir Thomas Brown in his 1658 study of urn burial titled *Hydriotaphia*.

Douglas J. Davies

See also Atheism and Death; Cremation; Death, Philosophical Perspectives; Funerals; Holocaust; Legalities of Death

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Cryonics

Cryonics is a technique whereby human or animal remains are preserved and stored at very low temperatures in the hope that future technological advances will allow resuscitation. Proponents of cryonics believe that if a person is preserved quickly enough following a pronouncement of legal death, the body's cells, especially those in the brain, may be revived with the help of future medical and scientific advances. Because of the belief that the cryopreserved may one day be revived, supporters do not consider people "absolutely dead" unless there is irreversible brain damage that would negate any hope for a future independent life. Rather, supporters argue that the clinically dead—traditionally defined as those without a heartbeat—are revived all the time thanks to cardiopulmonary resuscitation and thus there is reason to believe that, in time and with proper preservation techniques, all clinically dead people may indeed be cured. Based on the premise that cryonics may have the ability to save basic brain information, including memory and identity, proponents do not refer to the cryopreserved as deceased but rather as patients.

History of Cryonics

In 1962 Robert Ettiger first began thinking about cryonics as a preservation technique. As a physics professor in Michigan, Ettiger proposed that currently fatal diseases may not be as threatening in the distant future, as technology and medicine continue to improve, and that freezing a recently diseased person may allow for future resuscitation. His 1964 book *The Prospect of Immortality* is often considered the foundational text for many cryonicists although at roughly the same time, Evan Cooper founded the Life Extension Society, the first cryonics organization in the world. By 1965 Ettiger began the Cryonics Institute, located in Clinton Township, Michigan, which was the first organization to successfully cryopreserve a human, Dr. James Bedford, a 73-year-old professor. Dr. Bedford still remains suspended in liquid nitrogen, although cryonicists currently use much more sophisticated preservation techniques. At the time of printing, the Cryonics Institute holds 87 patients, more patients than any other cryonics institution. Other cryonics facilities in America include Alcor Life Extension Foundation (1972) in Scottsdale, Arizona, and Suspended Animation (2002) in Boynton Beach, Florida. A Russian organization, KrioRus, maintains a small facility with four patients, and Australia is currently planning on opening a facility in the near future. Support groups currently exist in Europe, Canada, and the United Kingdom but do not yet offer services.

The Cryonics Ideology

Cryonics has tremendous faith in the possibilities of science and technology to not only allow cryonically preserved patients to resume life but also to find cures for fatal diseases and illnesses, including cancer and AIDS, and perhaps even to find ways of reversing these conditions. Thus, in the distant future, scientific advancements may make it possible to eliminate the cryopreserveds' fatal disease and to repair those cells damaged in its destructive wake. No human or other mammal has been successfully cryopreserved and revived to date, although proponents point to successful preservation and revival of certain insects, human embryos, and small mammalian organs as evidence that human revival may one day be feasible, especially as molecular biology and nanotechnology continue to make advancements in cellular repair.

Cryopreservation

Cryopreservation requires that a body be cooled to –321°F, which is the boiling point of liquid

nitrogen. Oftentimes cryonics is equated with freezing, but this is not technically correct because freezing cells leads to mechanical and chemical damage. To prevent cellular freezing, chemicals are injected into the body that act as anti-freeze agents. These chemicals, called cryoprotectants, are necessary for vitrification, the process where a body is cooled and solidified without freezing. Vitrification was developed in the late 1990s by cryobiologists Gregory Fahy and Brian Wowk in an effort to preserve transplantable organs for those in need of new organs. Although vitrification prevents freezing to a large extent, it remains unknown how the toxicity of the cryoprotectants will affect patients' chances of revival in the future. However, cryonicists argue that the potential damage caused by the chemicals would be less severe and problematic than the damage caused by cellular freezing.

To limit the cellular damage that inevitably results upon legal death (i.e., when blood is no longer circulating to and from the heart), cynonicists suggest that ischemic injury, or the loss of oxygen to bodily tissues, can be controlled by "standing by" at a clinical death. Cryonics can only legally be performed on the clinically deceased, but this does not mean that all bodily cells have died. "Standing by" involves a cryonicist being at the bedside of a patient. Once the patient is pronounced legally dead, the technician would then perform CPR (cardiopulmonary resuscitation) in an effort to get blood circulating, albeit artificially, to maintain cellular life right up until the vitrification process begins. "Standing by" attempts to control ischemia injury, especially to the brain cells, which begins immediately after the heart ceases to beat. The logic is brain damage will be kept at a minimum, thus increasing the chances of a possible revival in the future.

Both scientists and cryonics advocates agree that revival is not achievable in the near future. For this to occur technology must be advanced enough to allow for bioengineering and nanotechnology to repair tissues and organs that did not properly vitrify and also to reverse the disease that led to the patient's death. This corrective process at the cellular level most likely would have to be completed prior to the body being warmed. Revival precludes people who suffered brain damage either before or after clinical death because cryonicists argue that the brain is not only the center for all other organ function but, more importantly, the site of identity and memory. Because brain information is so crucial to a cryopreserved person's chances of revival, the likelihood of remembering the past upon warming is the threshold for determining *legal death* (chance of revival if technology develops) and *absolute death* (no chance of revival either because the person was not cryonically preserved or brain damage is too severe to sustain independent life even in light of revival technology).

Contemporary Techniques

Currently, there are two techniques for cryonically preserving human bodies. The first method involves vitrification of the entire body and then suspending the remains in a chamber filled with liquid nitrogen for storage until revival becomes a scientific possibility, perhaps centuries into the future. The other technique is newer and remains somewhat more controversial.

Neurocryopreservation, or sometimes referred to simply as "neuro," is the vitrification and storage of only the client's head. Supporters of this method stress that only the information in the brain is important, as it will be possible to genetically engineer and re-create the body in the future with the help of nanotechnology. Not surprisingly, "neuro" is less labor intensive and requires less storage space, thus making it a more affordable preservation option compared to full body cryonics. Because both methods have yet to be successful, it remains unclear as to which may be more effective and conducive to future revival.

Proponents of full body storage argue that while the head is indeed critically important, it is not sufficient for a fully functional revival. The body is believed to be the site of memory and identity as well as the brain, especially concerning muscle memory and fine motor skills. While it may indeed be possible to regenerate a body based upon the information in the brain, this group of cryonicists worry about the extent to which the person will feel alienation or discomfort compared to those preserved with their original body. Full-body supporters are also concerned about the negative public relations that may come from severing and storing human heads as well as suspicion around possible financial motives given that it is much

more cost-effective for organizations to store only heads as opposed to entire bodies. On the other hand, neuro cryonicists believe the head is sufficient and that the lower costs make cryonics more appealing and feasible to potential patients.

Cryonics: Legal and Economic Aspects

Despite the fact that advocates do not consider their patients dead, cryonics can only be applied to the legally dead after a medical doctor has issued a death certificate. As such, it is considered a disposal technique, not unlike those of cremation and interment. However, unlike burial and cremation, cryonics is more time-sensitive inasmuch as the goal is to preserve as much brain function as possible prior to vitrification and storage. One option is to arrange to have a stand-by team alongside the dying patient. Another option is to have a local funeral director take possession of the body and prepare it to cryonicists' specifications so it can then be transferred to a cryonics facility.

Cryonics is a relatively new process and it requires advanced technology and long-term storage, possibly for centuries until revival is a scientific possibility. As such, cryopreservation is quite costly. The organizations offering the service vary greatly in price; estimates range from $28,000 (the price for the 2008) to $155,000 and depend upon whether the entire body or just the deceased's head is vitrified and stored. Additional costs also apply in order to secure bedside service where a cryonics team begins immediately cooling. Oftentimes, before reaching the cryonics facility, a local funeral director will be hired at additional costs to remove the body and prepare it, especially if the client is not geographically close. In order to be cryonically preserved, a person or his or her next-of-kin must become members of a cryonic organization with dues required prior to the client's death. Depending on the organization, some demand one-time membership dues whereas others also collect monthly dues. The major payment due at the time of vitrification and storage is typically paid for with life insurance policies. The Cryonics Institute, the largest facility in America, suggests that those interested in membership take $200,000 in life insurance as to cover any future price increases, but a minimum of $100,000 is highly recommended for those who cannot afford to pay with cash.

Caitlin E. Slodden

See also Death Care Industry; Death in the Future; Defining and Conceptualizing Death; Legalities of Death; Life Insurance

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Cult Deaths

There is no single agreed-upon academic definition for the word *cult*, although it typically refers to a minority religious group, possibly with a charismatic leader, whose beliefs and practices are at variance from those of the majority culture. In popular parlance, the word *cult* is used to refer to any minority religious group that provokes concern, anxiety, and fear. Much of the contemporary anxiety about cults and minority religions is related to several well-publicized cases of suicide, murder, and terrorism on the part of a few religious groups in the final quarter of the 20th century. Incidences of murder and suicide involving members of minority religious movements are often described as "cult deaths."

The study of cult deaths developed in reaction to these violent deaths involving minority religions. Scholars in a variety of disciplines identified a need to examine, in an objective manner, the reasons why several minority religions had turned violent. The media reports of these incidents of apocalyptic violence tended to be biased, often depicting the groups concerned as "evil cults" with manipulative and "deranged" leaders who "brainwashed"

converts. As a result, the general public assumed that new religious movements (NRMs) were essentially dangerous and violent. Thus, in the opinion of many analysts, NRMs were groups that should be controlled or even prohibited. An anticult movement developed with the goal of protecting potential converts from, in their opinion, being coerced or even "brainwashed" into joining cults.

Approaches to the study of cult deaths have included theoretical analysis, in-depth case studies, and comparative analyses of the empirical research. Such research has focused on exploring predisposing factors that may turn NRMs toward violence. The rest of this entry addresses these issues in greater detail.

Historic Overview

In 1978, over 900 members of the Peoples Temple, including over 200 children, were killed or committed suicide in Jonestown, Guyana. In 1993, 74 members of the Branch Davidians, a Seventh-day Adventist sect, died as a result of a 51-day standoff with the U.S. government at Waco, Texas. Between 1994 and 1997, around 74 members of the secretive Order of the Solar Temple died in a series of ritualized murders or suicides in Quebec, Switzerland, and France. Between 1990 and 1995 the Japanese NRM Aum Shinrikyo carried out a series of attacks on the public, culminating in a Sarin gas attack in the Tokyo underground on March 20, 1995: Around 5,500 commuters were injured, and 12 were killed. In 1997, 38 members of Heaven's Gate committed suicide after their leader convinced them that a spaceship (supposedly hidden behind the passing comet Hale-Bopp) would rescue their souls from the pending destruction of planet Earth. In early 2000, around 780 members of The Movement for the Restoration of the Ten Commandments of God, a Catholic splinter group based in Uganda, also died in a series of murder-suicides. Put in perspective, this means that around 3.5% of NRMs known to the British information center have turned violent.

Problems With the Term *Cult*

In academic circles the term *cult* is used in a technical sense with no evaluative connotations. It is sometimes defined as an organized system of worship focused on a person or an object of reverence. Today, however, it is most commonly used in derogatory ways. In popular parlance it can refer to religious groups that are seen as deviating from the mainstream and as dangerous movements whose leaders manipulate innocent converts into committing illegal and unusual acts that they would otherwise never consider committing. The media and the anticult movement frequently describe this process as *brainwashing*, a term which, like the term *cult*, is generally avoided by scholars. Various studies have shown that converts join and leave NRMs of their own volition, albeit within an environment of sometimes considerable influence. From an academic perspective the concept of brainwashing is little more than a way of giving a name to a process for which families or friends of converts fail to find other explanations. Converts often dramatically change their lifestyles and beliefs (by, e.g., adopting a new name, changing their diet, living communally, giving up material belongings), and families and friends cannot accept that the convert could have changed to such an extent without having been manipulated against his or her will. A common explanation has been that leaders of NRMs exert irresistible and irreversible mind control techniques over potential converts. Several studies have shown that the majority of NRMs have high turnover rates, thus indicating that their techniques are neither irresistible nor irreversible.

Millennialism

One commonly shared characteristic of NRMs that have turned toward violence is having apocalyptic ideas at the core of their beliefs. One strand of millennial literature (frequently based on biblical sources such as the book of Revelation) predicts that earthly perfection will come to an end after a cycle of 1,000 years, culminating in the destruction of evil. Today, academics often use the term *millennialism*, removed from its original Judeo-Christian context and referring instead to a belief in the imminent end of the world, in terrestrial salvation, and in the development of a millennial kingdom (this-worldly or other-worldly). Some scholars have made a distinction between catastrophic and progressive millennialism.

Catastrophic millennialism is characterized by a pessimistic view of humanity and society. Humanity is regarded as so sinful that the world needs to be destroyed and created anew. In contrast, progressive millennialism is characterized by an optimistic view of human nature; this view was prevalent in the 19th century. The positive attributes of humans are seen as gradually improving the world.

Followers of catastrophic millennial groups believe that humanity suffers from a dearth of positive attributes and the millennial kingdom on earth can be established only by the use of violence and destruction. Both types of millennial groups often involve messianism, the belief in a person who has been empowered by God to create the millennial kingdom. A dualistic worldview dominates: The world is divided into good and evil, and/or us and them, and often leads to predicting, and in some cases even producing, conflict.

The two categories of millennial groups are not mutually exclusive. If a particular movement perceives itself as successful in helping to facilitate the millennial kingdom, the catastrophic aspects of millennialism may well recede and progressive aspects may become more dominant. If there is any conflict with external forces, the catastrophic expectancies and the dualistic worldview might become exaggerated. If catastrophic millennial groups feel persecuted by external forces and additionally sense that they are failing in achieving their millennial goal, it is possible that members would be willing to achieve this through the use of violence.

Another factor that may influence whether a millennial group turns to violence is whether the group has abandoned hope for the salvation of nonmembers. If this is not regarded as a possibility, efforts will be concentrated on the salvation of group members and violence will be more likely. The result can be violence directed at nonmembers who are perceived as the enemy, inwardly directed violence to control dissidents, or committing mass suicide in order to remove the group from an evil world and take it to a better place, or a combination of all three. However, most NRMs do not turn violent but adopt a more passive approach, believing that it is God's role, not the role of the believers, to conduct millenarian violence.

Predisposing Factors Leading to Violence

Millenarian groups share certain characteristics that may predispose them to become violent. These factors are not sufficient causes in themselves. John Walliss has identified three interlinked groups of predisposing factors:

1. Inherent Violence and Antinomianism of Millenarian Ideologies

Millenarian ideologies can have a predisposition to turn toward violence, as they often draw on violence described in apocalyptic texts such as the book of Revelation. Millenarian ideologies are often antinomian; a specific group might see itself as being under no obligation to follow the legal and moral laws prescribed by religious authorities. If one believes that one is living in the end-time and that the prevailing social order will be overthrown by God, it is quite likely that the individual will want to reject or change the current social order; this situation can make millenarian groups quite confrontational. Their ideologies have been described as "exemplary dualism," referring to the fact that millenarian NRMs often do not only see opposing groups merely as groups with different views but as being inherently evil.

2. Charismatic Leadership

Charismatic leaders require from followers an unchallenged belief that they have exceptional powers enabling them to accomplish a specific mission. In certain cases followers believe that their leader is, or has been, in direct contact with God. Charismatic leadership can be precarious in nature because such leaders constantly have to undertake "legitimation work" to demonstrate their charisma in order to retain their authority. If, for some reason, opportunities for legitimation are no longer available, the leader experiences a crisis of charismatic authority, which increases the risk of volatility and violence.

Cult critics frequently claim that it is the "insane" charismatic leaders that make these groups volatile, but it has been shown that it can be the breakdown of charismatic leadership rather than charismatic leadership itself that increases volatility. It is undeniable, however, that leaders of some groups do exert a remarkable amount of control and pressure on the group and the individual members.

3. Totalistic Nature of NRMs

The totalistic or authoritarian nature of some NRMs predisposes them toward violence. World-rejecting NRMs are characterized by a strong "us-them" dichotomy, accompanied by a physical and/or ideological distancing of themselves from the rest of society. During this process the convert is resocialized according to the group's philosophy. The greater the extent of the resocialization is, the more likely the individual is to arrive at a state that Edgar W. Mills termed *supercommitment*, where the individual is no longer an autonomous entity but displays unquestioning obedience. Tendencies toward such a state rapidly increase if a group has isolated itself so much that members are no longer exposed to values and norms differing from those of the group.

Factors That Can Turn Predisposed Groups Violent

Proponents of the interpretive approach state that millenarian violence is largely reactionary in nature and that NRMs tend to become violent only when members feel that their very existence is at stake or when they feel threatened by external opponents, such as governments, the media, and anticult activists. During a process termed *deviance amplification*, small initial deviation may spiral through processes of labeling and overreacting. Actions of opposing groups are interpreted as hostile when they are not necessarily so.

This process is connected to the fact that these groups, like any religious group, possess an "ultimate concern" that overrides any other concerns a convert might have. Most individuals would give up or change their millennial goal under difficult circumstances, but members of NRMs involved in violence are willing to kill or die for their ultimate concern. External opposition is unlikely to be a sufficient cause in itself, but it can play an important role as a catalyst to the internal crisis.

Types of Catastrophic Violent Millennial Movements

Catherine Wessinger categorized catastrophic millennial groups involved in violence into fragile, assaulted, and revolutionary movements. Millennial groups can have features of each type simultaneously and can move from one category to the other as they develop.

Fragile Millennial Groups

Fragile catastrophic millennial groups initiate violence in an attempt to preserve their millennial goal. Both the Peoples Temple and Aum Shinrikyo are examples of such groups. Both Jim Jones and Shoko Asahara, the groups' respective leaders, fostered internal weaknesses and tensions by setting millennial goals for the group that were impossible to achieve. This meant that they gradually failed to reassert their charismatic authority and the groups' millennial goals were perceived to be under threat. The Jonestown commune was suffering financially and from Jones's increasingly erratic behavior. Shoko Asahara, a self-proclaimed Buddha, prophesized that a nuclear disaster would end the world in 1999 unless the movement grew to 30,000 members. The group only grew to 10,000 members, which was not enough to establish the Buddhist millennial kingdom, and the group's criminal activities (members killed Tsutsumi Sakamoto, a lawyer who threatened to sue and potentially bankrupt the group) made group members feel persecuted when they were faced with external opponents such as law enforcement agents. They performed a series of murders before the attack on the underground in order to minimize any disruption to the group caused by defectors and opponents. The reaction of both groups was to turn inward and depict the outside world as essentially evil and sinful, increasing the totalistic nature of the groups. The Peoples Temple reacted by attacking and killing Congressman Leo Ryan (D-CA) and members of his party. Nearly all the members first killed their children and then committed suicide. The aim of the gas attack was to stop Japanese police from carrying out raids on the movement's communes.

The Order of The Solar Temple and Heaven's Gate also are examples of fragile millennial groups. The Solar Temple was a secret society in the neo-templar tradition drawing on Western esotericism. An increasing number of defectors, the revolt of their Quebec commune against the group's Eurocentric hierarchy, the failing health of their leader, and the public criticism of their leader by his daughter created internal stresses. The group

was under investigation by international police and had received negative publicity in Quebec. This was interpreted as a sign that humanity was not evolving to the higher state of consciousness that was considered a prerequisite for entry to the Age of Aquarius. This shifted their "progressive" expectations to "catastrophic" ones. In the 1990s the leadership decided that the end-time was imminent and that salvation was possible through ritualized suicides that would enable followers to transfer to another planet. Core members committed suicide, whereas those regarded as traitors were killed, as were those who were thought to be too weak and needing help to make the transition.

Members of Heaven's Gate believed that the earth was about to be destroyed, that humankind was beyond hope of being saved, and that their members were part of an elect group to be saved by benevolent extraterrestrials who were waiting in a spaceship hidden behind the Hale-Bopp comet. The spaceships failed to appear, and one of the leaders had already died. The decision was taken that the best option to attain salvation was ritualized suicide.

Assaulted Millennial Groups

Assaulted millennial groups are characterized by having been attacked by law enforcement agents who regarded them as dangerous. An example of such a group is the Branch Davidians, who were involved in a standoff with the Bureau of Alcohol, Tobacco and Firearms (ATF) and the Federal Bureau of Investigation (FBI) at Waco, Texas. What distinguished this group from fragile groups such as the Peoples Temple is that they never saw their millennial goal under threat. Being attacked only confirmed leader David Koresh's prophesies about the violence during the end-time and legitimized his charismatic authority. Throughout the siege there were ongoing negotiations with the FBI. They felt persecuted and eventually were willing to sacrifice their lives. The conduct of the FBI was heavily criticized. The Waco incident is a clear example of deviance amplification. Suggestions for a nonviolent outcome in a siege situation have been to offer the group the ability to hold on to their millennial goal even after surrendering. During the assault on April 19, 1993, the group must have believed that the prophecy was being fulfilled with their martyrdom. Seventy-four members died as a result of the attack; only nine members present in the house survived, some of whom have been sentenced to prison for being involved in the killing of ATF agents.

Revolutionary Millennial Movements

By definition, groups falling into the category of revolutionary millennial movements have an inherent predisposition for violence because they want to overthrow what they consider to be the illicit and evil government. Followers of such movements see the need to destroy the government violently in order to establish the millennial kingdom prescribed by God. An example of such movements is the Montana Freemen, an armed group who were involved in a siege by the FBI in 1996. They believed in individual sovereignty, wanted to establish their own government, and intended to overthrow the U.S. federal government. During this incident the FBI were advised to offer the group the option of surrendering without giving up their ultimate cause. The siege ended without injuries on either side.

Fortunately there have not been any cult deaths in the conventional sense in the past few years. The increase of terrorism and the number of suicide bombers who are willing to die for achieving their millennial goals has opened up a new area for research into the topic of cult deaths.

Silke Steidinger

See also Death, Anthropological Perspectives; Last Judgment, The; Martyrs and Martyrdom; Massacres; Terrorism, International

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Curses and Hexes

The English word *hex* is derived from the German word *Hexe*, used to describe a witch or a curse. *Curse* is derived from the Old English term *curs* and is used to describe magically induced misfortune, although in modern usage it also refers to poor luck and bad language.

In the context of the human experience, curses and hexes are essentially the same and can be seen across human society; evidence for magical curses can be found in modern, medieval, antique, and primitive societies. These types of magical devices can be used for two purposes: to invoke the dead, spirits, or demons against the living or to protect the dead from the living or the living from the dead. The worldwide use of curses and hexes has led some psychologists to describe it as a subconscious rejection of humanity's inheriting mortality. This entry demonstrates this universality by describing cases from ancient Egypt, Rome, and Scandinavia, as well as medieval Britain. Cases for modern curses also are described, both in anthropological studies and in Western society, showing that they are not part of a religious experience but answer a much more basic need for control in the human psyche.

Curses and Hexes Used for Protecting the Living From the Dead

Hervör, daughter,
Why call you so?
Why such fell curses?
You do yourself ill.
Mad must you be,
All too witless,
And lost to wisdom
To rouse dead men. (Ellis, 1968, p. 160)

In antiquity there was a strong relationship between magic, curses, and the dead. This quotation was taken from the *Hervarar Saga* (IV), written originally in the Old Norse language. Like the rest of the Viking sagas, it provides a valuable historical insight into Old Norse beliefs. This particular saga deals with the story of Hervör, who travels to a haunted island where her dead brothers and father were buried. She seeks the magic sword Tyrfing. Despite her father revealing the future to her, particularly the evils the sword will bring to her household, Hervör collects the weapon. Curses in Viking sagas have a series of similarities: They are usually conducted in a liminal landscape—those that divide the living and the dead, such as cemeteries or howes (barrows or barrow cemeteries, which are mounds of earth raised over a single grave or ship burial)—and they are usually curses against the dead or against the living using the dead, elves, giants, or spirits as proxies.

Curses and Hexes Used for Protecting the Dead From the Living

Protection of the dead was a very real problem in antiquity, especially if the deceased was interred with objects still valuable to the living. Indeed, most grave robbing took place in antiquity and when archaeological sites like the Egyptian Valley of the Kings were looted. Ancient Egyptian tombs were protected by a series of traps, such as pits and false doors, and also by curses. Beneath its wrappings, the mummified body was protected by amulets. Collections of funerary spells such as *The Book of the Dead* were painted on the walls of elite tombs; they threatened to send dangerous animals or curses to hunt down tomb robbers. Despite this protection, archaeologists have never been put off excavating ancient tombs, even after the curse of Tutankhamun became widely reported after the death of Lord Carnarvon, just 1 year after the tomb was open. Howard Carter, the archaeologist in charge for most of the excavation, lived

another 17 years. However, the curse of the mummy entered popular culture and has since given rise to cult films like *The Mummy* (1932), *The Mummy's Curse* (1944), and *The Mummy* (1999) and its sequels. Curses used for protection of the living from the dead are also called *necromancy*.

Curses and Hexes Using the Dead Against the Living

The second form of curses and hexes are those cast against a living victim. Curses were cast against the ancient Egyptians' enemies, and the names of foreign foes or traitors were inscribed on clay pots, tablets, or figurines, which were then broken (ritually killed) or buried in cemeteries to weaken or destroy the enemy. Ancient Roman curses were heavily influenced by Egyptian magical practices, and a collection of some 1,500 curse tablets survive. Over 100 tablets were discovered from the Roman baths in Bath, England, and 60 more from a well in Caesarea Maritima, Israel. Those examples were made of lead but, as they seem to have been relatively common, many more may have been written on less-durable materials like hide or wood. Although most curse tablets were found down wells, nailed to the floor, or in tombs, there does not seem to be a direct association between death and Roman curses. Indeed, many seem to have focused on theft, legal proceedings, and court cases and to have mostly evoked gods, although the dead feature occasionally.

Curses are common among African rural communities, particularly in isolated groups. The Arivonimamo people of Madagascar practice a cross-generational form of cursing, by which the dead can come to the living and demand offerings and special treatments on the threat of cursing their descendants. Although this is an extreme example of the relationship between the living and the dead, it highlights the importance of this relationship to empower curses and cursing. Evidence of curses in medieval Europe has been found, and the mummified remains of a cat, probably linked to some form of magic, were discovered within a medieval roof in Lavenham, Suffolk, England. Modern witchcraft does not place such an importance on the dead, and candle magic and other forms of passive magic are practiced. However, the discovery of an 1831 book by Walter Scott, *Letters on Demonology and Witchcraft*, within the surrounding ditch of a Bronze Age round barrow on Uffington Hill, England, is probably related to the recent interest in new age religions. Placing this book on an ancient burial site demonstrates the association of neopaganism and archaeology, particularly the ancient dead, as a source of mystery and empowerment.

In summary, curses and hexes are a form of magic that can be used either to protect the living or the dead or as an attack on the living, but in either case they almost always use the dead as a method of empowerment. Curses and hexes need not be part of a pagan religion; they are manifested in one form or another in most human societies. Indeed, they are not necessarily associated with religious belief at all but fulfill a much more basic need within the experience of being human.

Duncan Sayer

See also African Beliefs and Traditions; Ancient Egyptian Beliefs and Traditions; Denial of Death; Exhumation; Mythology; Necromancy; Witches

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Cyberfunerals

The cyberfuneral, also known as funeralcasting or memorial webcasting, is the broadcasting via the

World Wide Web of an event to commemorate one's life and death. A funeralcast can be viewed live or delayed ("on demand") on single monitors or projected onto a screen for a large audience. Some providers attach the funeral webcast to personalized web pages that include photos, video clips, or a PowerPoint presentation. This entry discusses the availability of and requirements for cyberfunerals, notes the benefits and potential drawbacks, and identifies the emerging policy, ethical, and legal issues.

Availability of and Requirements for Cyberfunerals

Holding a cyberfuneral is dependent upon the availability of a webcast funeral service provider having access to a specialized computer server capable of distributing the webcast onto the Internet. More than 24 hours' notice is generally required to organize the funeralcast technology. Moreover, the number of computers used to simultaneously host the cyberfuneral depends on the capacity of the server, as the fees for the service are influenced by this quantity.

A computer with a high-speed Internet connection is needed to view a cyberfuneral. According to the Metropolitan Cemeteries Board of Western Australia, most late-model personal computers have the equipment needed to view a webcast: a high-speed processor, a sound card, and a video program such as Windows Media Player or RealPlayer. Audience technical support may also be available to troubleshoot challenges that occur while viewing the cyberfuneral. A password is required and is obtained from the funeral service provider.

Benefits and Drawbacks of Cyberfunerals

It is generally important for an individual to observe a funeral ritual, but it is not necessary to be physically present at the service. For example, participation in funeral rituals may influence adjustment following a death; therefore, it is important to consider the effects of cyberfunerals. Barriers overcome by funeralcasting include time limitations created by geographic distance, work obligations, or the requirements of a religious or spiritual ritual such as burial within 24 hours (according to Jewish law), limitations relating to physical or health factors, travel costs, or the need to care for young children. Deployment overseas may prevent a member of the military from returning home for a loved one's funeral, and comrades of a fallen soldier may benefit from observing a cyberfuneral.

Other benefits include the ability to archive online a videotape of the ceremony, thereby making the funeral available for viewing after the actual service. Time differences, as well as the desire to watch the funeral more than one time, can be accommodated.

To some individuals, cyberfunerals may be considered too impersonal, as they are devoid of social interactions that define many traditional funeral rituals. The potential for a cyberfuneral to become an "isolation ritual" exists because of this lack of active participation. Webcasts preclude the provision of social support in-person. A potential disadvantage of cyberfunerals is that these events may decrease the amount of support available to the bereaved. Although the use of similar technology in a second site would allow for interaction, the addition of such technology could be considered by some as intrusive. The potential also exists for disruptive behavior or inappropriate comments that cannot be predicted or prevented.

Policy, Ethical, and Legal Issues

It is common practice to require a password to access a funeralcast; this provides a sense of "privacy" and control over access to the cyberfuneral to the family of the deceased. As of late 2007, however, no formal policies existed to govern functions relating to cyberfunerals conducted by funeral service providers. However, one common rule of etiquette has evolved—the disclosure of the webcast through a posting at the funeral home and an announcement prior to the service. At issue is the privacy of attendees who may not desire to appear in the webcast.

The legal issues of permissions, copyrights, and licensing fees also are relevant. Releases must be signed by the clergy and others who speak at the funeral granting permission for webcasting. Music licensing fees paid by the funeral home account for the period of time that the webcast is available for viewing. If the webcast will display professional

photographs or copyrighted images, copyright issues must be addressed.

Cyberfunerals will undoubtedly become more prevalent as younger generations of funeral directors begin to offer this service, as the public becomes educated about funeralcasting, and as members of Generation X and subsequent generations assume responsibility for making funeral arrangements. Future documentation of the impact of this unique and innovative addition to the repertoire of services to commemorate one's life and death presents an interesting and important task for thanatologists.

Carla Sofka

See also Cemeteries, Virtual; Christian Beliefs and Traditions; Funeral Industry; Funerals; Grief, Bereavement, and Mourning in Cross-Cultural Perspective; Jewish Beliefs and Traditions

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Dance of Death (*Danse Macabre*)

The dance of death, or *danse macabre*, seems to have first appeared as a practice in the late 13th and early 14th centuries. It was expressed as a dance in allegorical form in which a group of the dead led a group of the living in a dance procession down to their graves to show the living that all are equal in death and that no one will escape death. It did not matter how high a station in life a person achieved, how much wealth was accumulated, or how much respect was gained. All would eventually come to the same status as a decaying corpse or a skeletal figure. This was the great lesson taught to the living by the *danse macabre*.

Ironically the procession of the living persons in the dance was arranged according to their societal status in life. In various art forms the pope, kings, bishops, noblemen, and, last of all, the peasants and the poor, were in the line of procession from beginning to end. A part of the lesson of the equality of death was the metaphoric living people all arranged in their various statuses in life going down into the grave where all of them without exception became the rotting corpses and skeletons found in the graves. Implicit also was the fact that God would judge each of them equally, with his justice based on their faith and good works in life.

The practice of the dancing seems to combine several historical traditions related to death that developed over hundreds of years. These include dancing on the occasion of death in churches and cemeteries; the use of a skeleton to represent death with a later, more formalized picture of death represented as a skeletal figure dressed in a long black cloak and hood and carrying a long scythe (the "Grim Reaper"); and the expression of death in many and varied art forms (in which it would be expressed as the dance of death in the late Middle Ages and early Renaissance). The art forms included music, paintings, woodcuts, staged drama, poetry, and other forms of literature. The appearance of the dance of death is still seen in 21st-century music, art, and literature.

The practice of dancing as a funeral ritual is reported to have even preceded the Christian era of history. People danced at interment and cremation rites before the birth of Jesus. It was often frenzied and fast paced with the dancers often stripping off their clothing and dancing nude among and on top of the graves and tombs. This was unlike the dance of death in the Christian era, which was much slower, more formalized, ritualistic, and organized. In the earlier times, the dancing was seen as a celebration of the lives of those who were still alive to enjoy the many pleasures and fruits of the material life, whereas those who dwelled where they danced had lost all of this by their death and passing on to whatever afterlife or spiritual dimension that existed among the various societies of those times.

In the early Christian era from the 4th century onward, the Roman Catholic Church actively opposed and sought to suppress the inherited pagan practice of fast dancing, of life celebration, in the cemeteries during funeral rites, during

funeral masses or rituals, as well as in funeral processions and cemeteries. In spite of hundreds of papal and ecclesiastical orders and banning the practice, it continued through the centuries in varying degrees. Ivan Illich called the churches and cemeteries veritable dance floors as this practice continued at death rituals, such as funeral services and burial ceremonies, through hundreds of years of post-Christian history.

It was during the later Middle Ages that the *danse macabre* began to be emphasized in all its varied forms of artistic expression. The first appearances in poetry, plays, and some visual arts were recorded in the 12th century. It was not, however, until the late 1300s and 1400s that the fullest expression of the *danse* would be reached. It has been suggested by a number of sources that this is probably the result of large numbers of death that decimated the European population during this period, including the first great wave of the plague, or black death. Contributing factors to this high death rate included many dying of starvation from numerous famines during the 1300s as well as other diseases related to fevers and other infectious diseases coupled with famine and other related deaths.

Examples of the dance of death in the arts include the following:

- The first fresco painting in the cemetery of the Church of the Holy Innocents in Paris in 1424. Various individuals from different social strata of European life are portrayed dancing individually with a decaying corpse. To represent the universality and equality of death, each individual is dressed identically and possesses the same features. Similar paintings appeared in Basel, Switzerland, in 1440 and Lubeck, Germany, in 1463.
- Woodcuts were done in Paris in 1486.
- The first recorded dance of death carried out in a print shop was done in Lyon, France, in 1499.
- Plays and drama incorporated the *danse* theme during this same period. Early French themed plays were basic short dialogues between the victims of death and Death himself. Later in the same century costumed skeleton dancers were incorporated into the plays.
- A textbook was printed during the 1460s that included a talk to the emperor by the person Death. Poems came out of the 15th century as well.
- In later centuries musical compositions began to incorporate the theme of *danse macabre*. This has lasted to the present. In summary, the historical customs and traditions incorporated into the dance of death concept appeared in the later Middle Ages as dance and then as poetic expressions of the equality and inevitability of death to all people of all social stations. Death, most often personified as a skeleton dressed in a long, black cape and carrying a long harvesting scythe, either dialogued or danced with individuals of different social levels and then led them from the land of the living down into the grave where they either appeared themselves or saw others as rotting and decaying corpses or skeletal remains. The great moral lesson to be taught was that all should prepare for death and be prepared to be judged by God for their faith and good works in life.

J. Mack Welford

See also Depictions of Death in Art Form; Depictions of Death in Sculpture and Architecture

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Daoist Beliefs and Traditions

To appreciate and understand the Daoist (also, Taoist) perspectives on death and dying, it is first important to grasp what may be called the cosmological vision presented in Daoism. Life and death are seen as elements in a greater, cosmological whole, a whole patterned by "the Dao," the overarching sacred term for ultimate reality. This is an

ever-changing and interrelated whole with neither beginning nor end, within which we find ourselves, as does every other creature, great and small, in the middle: the heights above never end, no matter where or who we are, and the depths likewise have no limit. The Daoist learns to move within this whole as an integral and intimate part, living without care to alter what is seen to be a truly marvelous and beautiful cosmos, and so lives well and long. Death is as beautiful and welcome as any other part of this integral whole, this cosmos patterned by "Dao," and so to appreciate that fact, it is to Dao that we first turn.

Although it is now considered merely a legend that the most famous of all Daoists, Laozi (also known as Lao-tzu), on approaching a border gatekeeper, was asked about the meaning of the great and mysterious Dao, the first line of his equally famous text, the *Daodejing* (also, *Tao Te Ching*), makes a most appropriate response to such a query. For the opening line of the *Daodejing* sounds much like a disclaimer for all that follows, as well as a profound statement of Daoist philosophy. He said, quite simply: *Dao ke dao, fei chang dao*. This opening line to a text that ironically goes on for another 5,000 words is usually translated along these lines: "The Way that can be spoken of is not the constant Way." However, given the many meanings of the word "Dao" and with considerations to the structure of the Chinese language, it might be better to read this disclaimer as: "The Dao that can be Dao-ed is not the constant Dao." What does this mean? As a disclaimer, it means that when asked to define Dao, Laozi simply responded that there is no adequate response to that question. Dao, as the "way" of all things, is beyond any description conceivable. Likewise, it is beyond any pointing, practicing, instruction, teaching, learning, or activity, even beyond the mere lack of such attempts. And any such attempt to comprehend Dao, to manifest it in whatever shape or form imaginable, will not and cannot come close to the Dao that is "constant," or the Dao as what *endures*. The Dao, in its essence and its truest form, cannot itself be "Dao-ed," that is, set before us as defined.

Yet Dao is also called by Laozi the "mother" of all things, meaning that all that exists arises out of Dao and will eventually also return back into Dao. Thus, no matter how "beyond" Dao is in its deepest essence, it is also most intimate to all that lives as well as all that dies. Dao is not a transcendent power or deity that lords over creation. Rather, Dao is the fertile ground out of which all arises, as well as that ground into which all must pass once again, without ever having left its embrace. The word itself, an ideogram, is composed of the word for a human head together with a word meaning "to proceed, to go forward," this second component looking much like a human foot. So the word embodies both a verbal and a nominal sense, and one can see both movement and direction within the word, especially evident insofar as an "eye" is part of the word meaning "human head." Dao is thus not only "the" Way, as a designated path or roadway, but also "going" on a way, making for some direction. In the ultimate sense, Dao cannot thus be itself "Dao-ed," for it is the Way *of* all things, the intelligent movement that infuses and guides all existence so inherently, so intimately that it cannot be brought before our eyes. But at the same time, Dao shows traces in this world of phenomenal existence because all of nature is itself, one could say, Dao-ed. This raises an interesting possibility, one that is at the heart of understanding the Daoist approaches to both life and death. Laozi made it quite clear that the Dao that can be Dao-ed is not the constant Dao, but what of the Dao that *can* be Dao-ed?

In Chapter 42 of the *Daodejing,* Laozi says: "Dao births one, one births two, two births three and three births the myriad things of existence." As great mother and sustainer of all existence, Dao first opens as "one," the Great One (*taiyi*), as what cannot be made more simple, for it is all uniting and all united. This Great One is also called the Supremely Empty (*wuji*), for it is the emptiness from which all existence flows and which yet contains all as the infinite. This was later diagrammed as the empty circle, and might designate the Dao beyond all comprehension, yet holding all of existence. The two that arise from this empty one are the pair yin and yang, whose diagram was also later called the Supreme Ultimate (*taiji*), for it represents the most fundamental features of all the manifested world of forms: change and relationship. Indeed, for Daoism all change *is* relationship and every relationship is inherently *changing*. The wisdom of this symbol (usually referred to as the yin and yang symbol) is that it succinctly captures the basic features of all change and relationship. Namely, all relational change

implies the following: (a) a polarity of correlative pairs, ultimately referred to as yin and yang, although these are merely symbolic of the infinite varieties of polarities found in nature, such as light and dark, cold and hot, masculine and feminine; (b) a cyclic or ever-returning movement, as the forms of change all recur; (c) the mutual birthing of these polarities (*xiang sheng*), as when taken to an extreme, yin will revert to yang, and also the fact that one inherently gives rise to the other, as is said even of being and nonbeing, life and death; and (d) the intimate interrelationship of all that exists, a fact of existence so profound that every part of creation is the direct effect of and efficacious cause for the whole of existence. The interplay of the two form the intricate, contextual web of all existence, manifested by Dao. Taken together, these—the Great One and the Supreme Ultimate pair of yin and yang—form the "three" that give rise to all creation. One might think of it as the empty circle of the One being "filled in" by the yin and the yang, such that the Two could not manifest without that emptiness and yet, quite paradoxically, the emptiness could not be recognized if not for the forms of existence changing in their multifarious relationships.

The cosmological view afforded by this understanding of Dao, both as unmanifested (the Dao that cannot be Dao-ed) as well as manifested (the myriad things seen through the lens of the yin and yang), is one of continual transformation (*wuhua,* the "transformation of things"). There is no force outside of the changing and infinite context that steers the play of existence, and there is, at least for the classical Daoists Laozi and Zhuangzi (also, Chuang-tzu), no moral value to what happens, nor a judge or process that decides one's fate based on the morality of one's actions. In fact, Laozi states quite clearly (in Chapter 18) that when the great Dao was lost, or abandoned, the virtues of humaneness and righteousness appeared. Although this was to change later in more ritualistically based religious forms of Daoism, the philosophical backdrop is a view of the cosmos as inherently ordered or patterned, while also spontaneously free. At the appropriate time, we are born, meaning the transformations of things leads to the gathering of energy that *is* oneself, and when the time is ripe, we die. Nothing is truly one's own. As Zhuangzi has it (Chapter 22 of the *Zhuangzi*), we are the very breath (*qi*) of the cosmos, of "heaven and earth," so who are we to either revel in life or decry death? Such evaluative thoughts only obscure and darken Dao, and such desires—to dictate the particulars of one's life or its course, or to fear and seek to avoid death—do not allow us to observe the mysteries of Dao, particularly its tenuous nature as the One. Zhuangzi uses the image of a blacksmith hammering a piece of metal into shape to depict how strange it would be for one to revolt against this process of change, for if the metal were to stand up and beg to be cast in a particular form, the smith would surely think it a most cursed piece of metal! For us heaven and earth are the furnace, and so it is best if wherever the "creator" might send us is also where we most wish to go.

This thoroughly integrated, contextual process of transformation is also completely without boundaries or borders, and it must not be forgotten that the two of yin and yang are not a duality, nor is there anything that is truly separate from this processive whole. Besides the fact that the Great One, Dao as unmanifested emptiness pervading all existence, "unites" all the myriad things, there is also the fact that the "breath" of which we and all creatures are made, qi, is likewise the vital energy that informs all creatures and *all phenomenal aspects* of creation. This means that what we call mind is not separate from body, nor is awareness separate from its object. As part of the interplay of taiji, qi can be characterized as essentially differentiated by yin and yang, the more diffuse, subtle, or ethereal qi being yang in nature, while the more dense, gross, and substantial qi is yin in nature. In terms of qi, Dao birthed the primordial qi (*yuanqi*), which then separated, according to the two of yin and yang, into heaven (*yangqi*) and earth (*yinqi*). As with all other elements of the cosmos, heaven and earth (*tiandi*) are not separate or separable and do not primarily designate specific places as unrealizable or asymptotic limits to yinqi and yangqi. As humans, we find ourselves between these limits, and as such we complete the "three" in yet another sense. As between, we are inherently contextualized (as opposed to "composed") by heaven and earth, yangqi and yinqi, and experience life as the ever-changing flow between heaven and earth. Our very bodies/minds are contexts of yinqi elements, such as blood, and yangqi elements such as qi itself, an ethereal soul that survives

death (the *hun*), as well as a corporeal soul that dies with the body (the *po*). Shaped as we are by Dao and infused with inherently relational elements (yinqi and yangqi), "life" and "death" are simply arbitrary markers, unreal borders, to what is in fact ever processing, ever changing, and intricately interrelated to the whole of existence by the One. This process of living in the middle of all contraries, between heaven and earth, is naturally "so-of-itself" (*ziran*) and is the space that Laozi likens to a bellows that inexhaustively, spontaneously pours forth all creation and which, invariably, swallows them back into itself again.

The priority for classical Daoism is thus in seeing things as they are, which means *responding* with things as they continually, relationally transform, and not becoming trapped by our judgments of right and wrong, good and bad, for they ultimately lead us into conflict, not only with each other but especially with what is, as it is. For when we desire things to go a certain way, we must at some point resist the flow when it does not align with our judgments, when it runs counter to our evaluative thinking. And the greater our resistance, the greater will be the force of our effort to change what already is, or the greater we must try to coerce change through willful action. But according to Laozi, Dao does nothing, yet nothing is left undone. That is, Dao by its very nature is effortless, spontaneous, and free flowing, characterized most essentially by *being,* not by doing. This is what Laozi calls *wuwei,* noncoercive action, or action that resonates with the inherent emptiness of Dao as the One, as opposed to the purposeful action that arises from evaluative thought. What is human is to resist the spontaneous process of Dao and impose an artificial order onto the natural world, an order of how we *think* things should be. This not only wears out our vital presence (*de*), but obscures the profound depths of Dao, the depths that open to the limitless, the infinite, the boundless, and the unliving and undead. That is, it obscures the Dao beyond comprehension and so blocks our realizing the inherent intimacy with this sacred Dao. Or as Zhuangzi has it (Chapter 23), we cannot become enlightened to "heaven's gate" (*tianmen*), through which all passes into existence and back out again, and through which gate flows the "treasury of heaven," a treasury that the sage knows well.

The Daoist sage, having the form of a human but lacking the "feelings" of humans (evaluative judgments and their inherent desires), is also described by Zhuangzi as being selfless, spiritual, and without name or renown. As the "genuine person" (*zhenren*), the sage understands the spontaneous workings of heaven as well as of his or her fellow human beings but, bound by neither, is free to consort with all things. He or she neither loves life nor fears death, seeing them together as a single body, and is able to roam the world unperturbed, having found a home in the boundless. Living beyond the bounds of the two (or the human realm of distinctions), yet still one with the transformations of things, such a sage was said to be able to enter fire without being burned and enter water without becoming wet, even to soar the heavens, sustained only by the vapors and dew. Laozi similarly describes the sage as having the softness and suppleness of an infant, while appearing "blockish" and dull to his or her fellows, for the sage remained as the uncarved block: utterly simple. Certainly such a genuine or true person realizes, in the most profound and ecstatic sense, his or her oneness with the supreme emptiness of Dao, the Dao that cannot be Dao-ed, and so also realizes the source of all life, the origin of all that exists, as that which itself neither lives nor dies, and so is, in a way, immortal.

Surely this is the freedom that Zhuangzi so rapturously describes, and this is the enlightenment (*ming*) that "evens things out," that loosens the grip of the mind from its conceptual dualities and perspectives and allows one to "live out the years assigned by heaven." For Daoists such as Zhuangzi, this was the epitome: to flow with the coursing Way of all things without the slightest resistance, so as to never dull our blade of vital presence (de), much like the fabled Cook Ding was able to carve oxen so expertly that his knife never needed honing. To cleave to the One without disturbing the transformations of things is to know, beyond comprehension, the emptiness of the enduring Dao, the being beyond all dualities, including life and death. As for techniques to attain such a state, Zhuangzi gives us the ways of "forgetting all things" and the "fasting of the heart-mind" (*xin*), both on par with "becoming tenuous" or empty to the utmost, as advised by Laozi (Chapter 16). That is, the mind by its very nature divides, sorts, classifies, and

defines all that arises, even to the extent that it gives boundaries to, and so constitutes, what is even called a "thing," and when we take these mentally constituted boundaries as real, we miss the One, the empty Dao, and so it is as if heaven's gate remains closed to our vision. This blindness is a common kind of "forgetfulness," but one that forgets what must not be forgotten; instead, Zhuangzi advises that we fast the mind of its life-blood and set outside of ourselves all distinctions, even those of body and self, invested in a kind of loss, such that, as Laozi says, we lose day by day until "nothing is done" (wuwei). Living beyond the world, what harm could befall one? Where is one to go? With the realization of the One, the entire universe can be known without leaving one's house, for all has been gathered together in the emptiness of Dao.

Of course, later Daoists were to devise many other techniques and methods for attaining immortality—sometimes in literal terms of physical immortality—to achieve the ecstatic wanderings described most vividly in the *Zhuangzi*. Typically these methods involve cleansing and harmonizing the energies of the body and mind, particularly the qi and the "essence" (*jing*), so as to either reduce or stop the aging process as well as to form a kind of spiritual fetus that may be entered upon death as a kind of immortal vehicle for the soul and spirit. These exercises require an intricate knowledge of the energies of the body/mind and involve active forms of meditation that employ rich images and symbols to both move and purify the qi and jing. Thus, knowledge of the natural transformations of the body/mind is supplemented with a kind of alchemical transformation, whereby the coarse energies are purified into higher forms of spirit in the hope of attaining immortality. This is clearly not implicitly a resistance to the transformations of things, as it inherently makes use of the patterns of change and the relationship of yin and yang, as well as for the fact that such practice brings one more in alignment with the contextual, coursing Way of all things. Thereby, it may be recognized as being in fact a close neighbor to the "let it go, let it be" attitude of the classical Daoists, for such practices are parallel to the examples of craftspeople used by Zhuangzi to show how ultimate mastery goes "beyond skill" and exhibits effortless action (wuwei). When one does nothing yet nothing is left undone, the immortal has been realized.

Marty H. Heitz

See also Buddhist Beliefs and Traditions; Confucian Beliefs and Traditions; Immortality

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Databases

The reporting of death and its circumstances has been an important public health function throughout history, as societies try to account for when and how their members die. Increasingly powerful mainframe and personal computers, database software, and the Internet have revolutionized the reporting of death and have led to the development of databases in which large amounts of information about death can be stored electronically. These databases are maintained by various organizations, including public local, state, and federal agencies as well as private organizations. In the United States today, information about death is reported in many databases that have different data stewards and varying policies regarding access. This entry describes the various types of death databases, their uses, completeness, and accuracy.

Types of Death Databases

In the United States the standard death certificate reports the characteristics of the decedent as well

as the date, time, circumstances, and underlying cause of death. This document is completed by the decedent's physician, funeral director, or medical examiner, depending on the circumstances of death. Death certificates are usually collected by city or county governmental organizations and then transmitted to state vital statistics offices that are responsible for organizing and maintaining databases of electronic death records that contain information recorded on the death certificate. Both state and county offices respond to requests from relatives and other interested parties for individual death certificates. States may also make their databases available to researchers, although special permission is required for access to personal identifiers such as name and social security number. The individual states vary considerably with respect to how they treat the confidentiality of death records and how readily they make death records available. For example, the State of New Jersey provides free of charge annual files of public death records on its website, although special procedures must be followed to obtain personal identifiers. Other states are much more restrictive in making even public versions of their death records available. There is also variation concerning the amount states charge for individual death certificates as well as aggregate records.

Ultimately states provide their death records to the Centers for Disease Control and Prevention (CDC), which compiles reports about death in the United States. There is no readily available national database of death records or certificates in the United States, although the National Center for Health Statistics of the CDC supports the National Death Index (NDI), which is a death ascertainment index or matching service for investigators conducting medical and health research. The NDI does not include deaths that occurred prior to 1979 and is not available for administrative or genealogical uses. The NDI Plus, which is part of the NDI, includes selected items from the standard death certificate and can be obtained by researchers, who must make special application and pay the required search charges.

The Social Security Administration (SSA) Death Master File (DMF) is a national-level file that is extracted quarterly from the NUMIDENT, which contains information about each individual who has been assigned a social security number. The file itself contains decedent name, social security number, date of birth, date of death, state or county of residence, zip code of last residence, and zip code where last payment was received. The SSA-DMF contains over 80 million death records, which are culled from a variety of sources, including relatives, funeral directors, banks, post offices, and state vital statistics offices. Deaths occurring prior to 1960 are included, although most deaths are from 1960 and later. This file can be purchased by individuals and is also used by many different organizations whose missions are as diverse as credit reporting, mass mail marketing, or genealogy. Several genealogy sites offer free death record searches with the SSA-DMF. The SSA also offers a "presumed living" search service to health researchers. This service searches files in addition to the NUMIDENT to determine if an individual is alive. Researchers must apply to use this service and are required to pay fees.

There are other death databases that contain vital status information on select groups of individuals, such as veterans. Typically, access to these information systems is highly restricted. Examples of such databases include those maintained by the Department of Veterans Affairs and the Department of Defense. Both of these organizations, which provide a vast array of benefits to active duty and retired military personnel, need to have accurate vital status information on their beneficiaries. Another type of database is an obituary archive, which contains death notices from selected newspapers across the country. Again, the Internet provides easy access to these resources.

While obituary archives usually report deaths occurring within the past 10 years, there are many archival sources that report deaths from many years ago. These include county and state historical societies, state governments, and the U.S. Census Bureau, which makes its Decennial Census of Population and Housing publicly available 72 years later. Thus census records from 1790 through 1930 are available on microfiche located at the U.S. National Archives and Records Center in Washington, D.C., at archives regional centers, and at select federal records centers throughout the country. The Church of Jesus Christ of Latter-day Saints also has extensive genealogical resources and offers free death searches with the SSA-DMF

and other historical national and international databases it has developed.

Uses of Death Databases

As seen from this inventory, there are several uses of death databases. First, there are administrative uses in which the government tracks the vital status of individuals, as well as groups. Tracking individual vital status is critical, as both local and federal agencies (e.g. SSA, Department of Defense, state and county human service agencies) administer a variety of programs that provide income and other support to individuals. Second, both state and federal governments produce extensive reports about death in the aggregate; these reports include descriptions of the facts of death as recorded on the death certificate. At the national level, the CDC issues extensive reports about death, including date and time of death; decedent characteristics such as age, gender, race, veteran status, tobacco use, and occupation; underlying cause of death, including injuries; and place of death.

Death databases are also used extensively by private entities, including individuals and businesses. Individuals are often interested in learning more about their ancestors or may need to determine what has happened to a lost relative. With respect to business, the growing interest in genealogy, as well as the burgeoning use of the Internet, has led to the creation of numerous genealogy websites that offer both search services and software for developing genealogies. Corporations also need accurate and complete death databases for ensuring that deceased individuals do not receive benefits that cease at death. Mass mailing firms are also concerned with maintaining accurate lists, and a whole industry has developed around searching for hard-to-find individuals, including those who have died.

Researchers in medicine and epidemiology also need accurate and complete death databases, as vital status is a key outcome in most studies they conduct. Those researchers whose studies enroll thousands of subjects often do not have the resources to contact each participant to determine vital status. Moreover, searching the SSA-DMF one record at a time for a large number of individuals is not practical. Sufficiently funded studies will have the resources to purchase the SSA-DMF to permit searching for a large number of individuals. Such studies will also make use of the NDI and SSA "presumed living" search, although for studies with more than 100,000 subjects, searches can be costly.

Completeness and Accuracy

All parties who use death databases must be concerned about the completeness and accuracy of these information systems. The NDI is often viewed as the "gold standard," as it contains elements of the death certificate that is the basis for the reporting of death in the United States. However, access to the NDI is restricted to researchers, so for most, there will only be general concerns about completeness and accuracy. Many of these matters have to do with the validity of the underlying cause of death, which may be particularly difficult to determine in deaths due to external causes, such as accidents, assault, or intentional self-harm. In certain situations, the medical examiner or coroner must determine intent—that is, whether death was accidental or self-inflicted.

Although in some studies, performance of the SSA-DMF with respect to the NDI was favorable, there remain some concerns about completeness of the SSA-DMF. First, deaths of beneficiaries may be more likely to be reported than deaths of individuals who did not receive benefits. Consequently, reporting is more complete in the later ages of life than at the younger ones, as older individuals are more likely to be beneficiaries. Second, not all states report deaths to the SSA for purposes of identifying fraud and abuse. Despite these limitations, there are advantages to the SSA-DMF as compared to the NDI. First, the SSA-DMF includes deaths prior to 1979; second, it is widely accessible and inexpensive to use; third, it includes individuals who have a social security number and die outside the United States, whereas the NDI reports deaths occurring only in the United States and its territories; and fourth, misreporting of the social security number may be less frequent than other information on the death certificate. For researchers using a combination of the NDI, SSA-DMF, and the SSA, a "presumed living" search may be the optimal strategy for complete ascertainment of vital status.

Summary and Future Directions

In the United States there are numerous death databases, but only one with relatively complete current vital status information is available to the general public, including those interested in genealogy. The SSA-DMF has many advantages, although there remains the lingering question about its completeness. Access to death databases such as state death records or the NDI is restricted by purpose of use as well as privacy concerns. This may limit ascertainment of vital status for those who die at younger ages. It must be asked how much more information about death the general public needs to know. Aside from completeness, should the circumstances of death be made public? Although newspapers may report the circumstances of high-profile deaths, including those caused by assault or self-inflicted injuries, it is most likely that the circumstances of death will not be made available for all individuals who have died in recent years. However, details about the circumstances of death for individuals who died many years in the past are of interest, as evidenced by the growing number of websites with archives of death records from at least 50 years ago. Again, the potential of the Internet is virtually unlimited for the development of electronic historical death records, although sufficient resources are needed to digitize records, purchase servers, and develop websites. Development of these death databases will be of value to a variety of individuals and organizations who want to better understand the when and how of death in the past as well as today.

Charles Maynard

See also Causes of Death, Contemporary; Death Certificate; Death Notification Process; Mortality Rates, U.S.; Obituaries, Death Notices, and Necrology

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Day of the Dead

From early times to the present, Mexican culture has embodied themes of death, sacrifice, and destiny. Once a year, starting at the end of October, Mexicans celebrate death in a national fiesta known as *Día de los Muertos* (Day of the Dead). During the festival, the living invite their dead to join with the family and to share a meal and time together before they return to the land of the dead. This Mexican holiday originated with Aztec festivities held in late July and early August.

In the Aztec world, death was extremely important. The destiny of a soul after death was determined by the manner of death, rather than by conduct during life. The journey to the land of the dead differed depending on whether a person died suddenly or in a particular manner, such as by drowning or by lightning. Deaths in combat or in childbirth, as well as deaths in connection with ceremonial sacrifices, were especially significant. Warriors who died in battle went to a region in the sky where they accompanied the sun god on his daily journey from dawn to noon. The sun's warrior companions took the form of hummingbirds or butterflies, symbols associated with rebirth. Individuals who became sacrifices were awarded a glorious destiny in the third heaven, and women who died in childbirth (with a "prisoner" in the womb) were considered to have died just as honorably as warriors and had a place in

the heavens, accompanying the sun from midday until sunset.

Among the Aztecs, the creation of the world was made possible by sacrificial rites enacted by the gods, and human beings were obliged to return the favor. Sacrificial victims in Aztec rites were termed *teomicqueh,* the "divine dead." Within the divine–human covenant, they were participants in a destiny determined at the origin of the world. Through sacrifice, human beings participated in sustaining life on earth as well as in the heavens and the underworld.

When Spanish priests arrived in Mexico, they attempted, in vain, to suppress Aztec rituals for the dead. As a result, Día de los Muertos is now celebrated during the Catholic feasts of All Saints' and All Souls' Days. The Spanish contributed elements from the medieval tradition of the Feast of Fools (associated with *Carnaval; carne vale,* "farewell to the flesh"), where everything is open to criticism, ridicule, and mockery. This humorous tradition is part of Día de los Muertos. Thus, the fiesta combines ancient rituals and customs with features of introduced Catholic traditions. In many parts of Mexico and the southwestern United States, it is a popular holiday with observances of cultural and social importance.

Features of the Modern Fiesta

Día de los Muertos is a special occasion for communion between the living and the dead. The rituals, food, and objects, as well as particular practices of remembering the dead, vary throughout Mexico. During late October, the markets of the villages and towns are filled with special handmade items for the fiesta. In fact, some of the most interesting *cosas de muertos* (things of the dead) are designed to be eaten by the living. Bread in the shape of human bones, sugar-candy skulls, and cardboard coffins poke fun at death. Pulling on a string at the end of a cardboard coffin will open the top and pull up a skull-shaped *muerto* (dead one) to a sitting position. People from all walks of life are portrayed as *calaveras* (bones or skeletons.) The professor and the pilot are constructed of papier-mâché in the form of skeletons. In the marketplace, there are 3-foot-tall candles for lighting the gravesite and *cempaszuchitl* (marigold-like flowers) whose petals traditionally are strewn to guide the dead on the path to the family home.

Pan de muerto (bread of the dead) is an essential food for the fiesta. It is generally made from a light, sweet yeast batter and baked into a characteristic shape depending upon the region of the country. For example, the *pan de muerto* typical of Mexico City is a round loaf topped by a stylized skull and crossbones. In some places the round loaf is topped with dough in the shape of bones.

The tradition of the calavera as a central icon for the celebration of Día de los Muertos is thought to echo the Aztec skulls elaborately decorated for use as masks or offerings. The sugar skull is a form of calavera that is widely available in the marketplace. Made of sugar and water and decorated with reflective eyes and facial markings made of icing, the sugar skull has a place on the top for your name. In eating your own skull, the thought is that you become a *compadre* (companion) of death rather than its adversary. Sugar is also used to construct various animals who will accompany the dead on their journey to and from *Mictlan,* the place of the dead.

The calaveras sculpted in sugar, clay, or papier-mâché or created from elaborate paper cuttings are used as a reminder that all of us will, one day, become dead ones. Under each person's skin are those bones, and the calaveras send a message that we need to recognize that fact and become accustomed to the idea that we will die.

The tall candles used in the festival are placed on both the *ofrenda* (altar) and the grave. It is believed that the spirits of the dead need light to find their way back to the living on their journey to join us. In some communities, the quantity of candles signifies the number of dead ones who are being welcomed home.

As a part of the festival, the families go to the cemetery to prepare for the return of their dead. There are generally few, if any, caretakers in the graveyards of Mexico. The rituals of cleaning graves, repainting crosses, pulling weeds, redecorating stones, and decorating with flowers is both a rejuvenation of the gravesite and a display of welcome for the dead. Even in the "perpetual care" cemeteries of the United States where Día de los Muertos is celebrated, families will gather at graves to clean and decorate them in anticipation of their dead one's return. A party-like atmosphere

occurs in the graveyards with families, including children, visiting with each other and their dead loved ones. At night during the fiesta, in Xoxo, Oaxaca, the small cemetery is ablaze with lights from tall candles placed around the graves. A *mariachi* band circulates, playing tunes for the living and the dead while vendors sell food and drink.

During the festival, families build an ofrenda in the home. The placement, size, and materials used to construct the altar for the dead vary throughout Mexico. In general, an altar is covered with a cloth, although other coverings might be used depending on the region. Pictures of the deceased, and sacred images such as pictures of Mary, Jesus, or other saints (e.g., the Virgin de Guadalupe) are placed on the altar. Food for the ofrenda might include a labor-intensive dish of chicken *mole*—a spicy sauce of some 50 ingredients including chili peppers, peanuts, and chocolate—or other dishes that were favorites of the deceased. Items familiar to deceased loved ones, such as a package of a particular brand of cigarettes or a bottle of *mescal,* are set out to entice their spirits to return to the family during the fiesta.

When the ofrenda is complete, on the appropriate day determined by tradition, the dead are called home to be with the living. In some places, families set off rockets or large firecrackers to announce to the dead that it is time to come. In some communities, the dead will join the living in a meal, although only the dead may eat from the ofrenda. Children are warned that the sweets, bread, and delicious offerings are first given to the dead. The living will eventually eat them but only after much of their essence and flavor has been consumed by the dead.

Traditionally Día de los Muertos begins at midday on October 31, as bells toll to mark the return of dead children—*angelitos* (little angels)—whose purity of heart is said to make them effective in mediating between the world of the living and the realm of the supernatural. Such purity of heart is thought to be especially true of children under the age of 4. The next day, families gather at the church. Bells are again rung at noon to signify the departure of the "small defunct ones" (children) and the return of the "big defunct ones" (adults). Among the most traditional observances of the fiesta are those held in the Zapotec villages in the Valley of Oaxaca (such as Xoxo) and on the Island of Janitzio in Michoacán.

The celebration reaches its peak on the evening of November 1 and into the next morning, when thousands file into the small candle-illuminated graveyards carrying tamales, pumpkin marmalade, chicken mole, and pan de muerto. People sit on the graves and eat in the company of the dead ones. They bring guitars and violins and sing songs. There are concession stands where food for visitors is sold. The celebration goes on all night long. It is a happy occasion—a fiesta, not a time of mourning.

Significance of the Fiesta

In his study of Mexican identity, *The Labyrinth of Solitude,* poet and essayist Octavio Paz observes that Día de los Muertos is a time for revolting against ordinary modes of thought and action; the celebration reunites contradictory elements and principles, bringing about a renewal of life. The rituals honoring and remembering the dead not only connect members of the community, they also reinforce the belief that death is a transitional phase in which individuals continue to exist in a different plane while maintaining an important relationship with the living. Celebrants challenge the boundaries that ordinarily separate the dead from the living. The souls of the dead reassure the living of their continued protection, and the living reassure the dead that they will remember and nurture them in their daily lives. It is important that families pay their respects to the dead, but mourners are cautioned against shedding too many tears; excessive grief may make the pathway traveled by the dead slippery, burdening them with a tortuous journey as they return to the world of the living for this special celebration.

In Mexican culture, people often confront death with humorous sarcasm. Death is cast as an equalizer that not even the wealthiest or most privileged can escape. The emotional response to death is characterized by impatience, disdain, or irony. The skeleton has been called "Mexico's national totem." The popular engravings of Mexican artist José Guadalupe Posada resemble the medieval *danse macabre,* in which people from all walks of life dance with their own skeletons.

The somber mood of Hans Holbein's depiction of Die Totentanz, *or Dance of Death, contrasts with the treatment of the same theme by Mexican artist José Guadalupe Posada. In Holbein's medieval woodblock print,* The Child, *we see the anxiety of family members as the skeletal figure of death ominously takes a child; in Posada's print, there is a sense of gaiety and festivity. Although expressed differently, the two works convey a common message: Death comes to people in all walks of life; no one is exempt.*

Source: © Lynne Ann DeSpelder and Albert Lee Strickland from *The Last Dance: Encountering Death and Dying,* 8th ed. New York: McGraw-Hill, 2009. Reprinted with permission.

A striking awareness of death is displayed in graffiti and ornaments that decorate cars and buses. Newspapers revel in accounts of violent deaths, and obituaries are framed with conspicuous black borders. The suffering Savior is portrayed with bloody vividness. Mexican poetry is filled with similes comparing life's fragility to a dream, a flower, a river, or a passing breeze. Death is described as awakening from a dream-like existence.

Commenting on how these themes are displayed in modern-day Mexico, Paz says that death defines life. Death, like life, is not transferable. Folk sayings confirm this connection between death and identity: Tell me how you die and I will tell you who you are. Although a heightened awareness of death is part of everyday life in Mexican culture, it is given special emphasis during Día de los Muertos, as people gather to commemorate enduring ties between the living and the dead.

Lynne Ann DeSpelder and
Albert Lee Strickland

See also Ancestor Veneration, Japanese; Dance of Death (*Danse Macabre*)

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Death, Anthropological Perspectives

Death is not a new interest for anthropologists, but how it is depicted has changed. Typically, earlier ethnographers inserted death, a biological given, into their descriptions of rituals, religious beliefs, and memorial practices. Few theorized death itself. Since the latter part of the 20th century, however, physical death as a topic in its own right has become prominent, due in part to critical theory and concepts of biopower and biopolitics taken from the work of Michel Foucault. Other factors are the aging of the American population, new technologies for sustaining life, and the rise of palliative and hospice care. More recent anthropology explores death and clinical medicine, end-of-life decision making, the consequences for patients and families of life-extending technologies, changing styles of grief and bereavement, and ways the dying body is subjected to manipulation and variable interpretation. Controversies surrounding physician-assisted suicide, organ donation, and the highly publicized deaths of individuals trapped in long-term persistent vegetative states fuel this newer interest as well. This entry reviews first the ethnographic coverage of death in selected cultures. The work of anthropologists who study dying and its complications in the postmodern world of sophisticated technology and institutional medical management also is covered.

Theorizing Death

One of the earliest and still influential attempts to theorize death was that of Robert Hertz, a French anthropologist who in 1907 puzzled over secondary burial, reported among various groups in Sarawak. In this practice, bodies of the deceased are stored in large jars buried in the ground. After a time they are disinterred, the bones cleaned, and skulls displayed in the houses of their former owners. Versions of secondary burial are widespread in human societies (the medieval European traffic in sacred relics is an example), and Hertz argued they are more than mere curiosities. He saw the death beliefs and practices of any culture as elements in a coherent system built around three relationships: that between the living and a corpse; the inert body's release of vital spirit and its transition to a place of repose; and ongoing connections between these transported spirits or souls and remembering survivors. While the details and emphasis of course vary from place to place, the underlying system creates an orderliness that structures the sense of loss that any death inspires.

While not all subsequent ethnographers adopted the Hertz model, the abundance of ethnographic material they gathered can be conveniently presented in terms of its three-part relationships. The first, the preparation and disposal of a corpse, is foundational; body handling is an indicator of the significance of the deceased in life and an occasion for status display by the surviving family. That point is obvious enough if we compare the funeral practices associated with the death of a president with those for a pauper. It is equally evident in any funeral company's showroom, where caskets range from simple wood boxes to the expensively elaborate, and survivors are advised to choose something appropriate for the deceased. That pattern fits the expectations of a market-driven economy in which choice is one measure of consumer satisfaction. But even in an industrial society, it is not everyone's preference. Very much a

contrast is the intensive, ritually driven body washing and wrapping that is the task of a *chevra kaddisha,* a traditional Jewish burial society. Here the goal is to efface social markers, thereby purifying the corpse according to the principles of an ancient tradition. Simplicity is what matters; in preparation to meet its divine source, the self must be freed of the clutter of the mundane. That is true also for Hindus, who bring their dying to Banaras on the river Ganges. For them, the purifying agent is not water but fire. As death nears, the dying shun food and water, an austerity that will speed the departure of the *pran* (vital breath) from the corpse when it is burned on a pyre at the river's edge.

Strikingly different from these examples are the body disposal practices of the precontact Wari peoples of the Amazon, who once expressed their compassion for the dead in an unusual but, to them, sensible way. Out of respect, they cooked and ate portions of the corpse. Ground burial (probably suggested by missionaries and the current practice) was unacceptable because a buried body in a known location was a reminder of sadness whereas a consumed one was not. Eating was to eradicate memory, not preserve it. As Hertz theorized, this method of body disposal was congruent with Wari notions of personhood, cosmology, expression of grief, and memorialization. Personhood for them was a matter of relationships and lifelong reciprocities, less the internalized, nurtured self of American practice. Thus eating the deceased is a final act of sharing, the Wari way of making sense of the existential meaningless that every death implies.

Souls

At some point following death, a corpse gives up its animating principle, which then travels to some distant, perhaps sacred, place. This body/soul contrast is the second polarity in Hertz's three-part model. In the Hindu system, for example, the afterlife is variously depicted as reunion with ancestors, rebirth in another condition, or escape from the cycle of rebirth and dying altogether but, wherever it goes, the pran makes that transition more or less automatically. In other places, transcendent movement must be nudged along, sometimes strenuously. In rural areas of modern Greece, final entry into paradise is gained, in part, because the living labor on behalf of the deceased through prayers, church masses, and regular, even daily, grave visitations over a number of years.

A challenge also exists for the dead in areas of Sarawak, where souls arrive at a realm of ancestors only after a difficult and hazardous journey, sometimes characterized as travel up a river with many side streams that are confusing and dangerous. The current residents of Brittany in northwest France, however, dispense with all such effort despite a long history of death ceremonial. Consistent with modern doubts about older characterizations of heaven, purgatory, and hell, the Bretons' concern, quite literally, is nearness to relatives. A *caveau* (house-like structure) holding up to a dozen family caskets is built in the cemetery. Eternal rest with kin is more important than residence in a doubtful place of eternal light and angels. But North Americans who claim to have had a near-death experience would strongly disagree. They say they have been to the other side, traveling to it through a frightening tunnel of darkness and toward a Being of Light. On arrival they were reunited with family and friends. Whatever the truth of these claims, as narratives they have specific cultural and historical antecedents in the writings of the 18th-century intellectual Emanuel Swedenborg. He broke with the old medieval pattern of purgatory and hell and his mystical, almost domestic vision was subsequently popularized in the paintings of William Blake. It persists today in popular imagery in bereavement cards, sermons, cartoons, and a plethora of self-help spiritual guidebooks.

These accounts assume the singularity of a soul. In parts of Melanesia, however, individuals can have more than one soul, and that has its uses. Multiple souls have diagnostic significance, their gradual departure one after the other an explanation for late-life illnesses and slow decline into death. Souls commonly leave the body, as in dreaming, but when they travel so far that they cannot reconnect with it, death results. Whether multiple or singular, however, the action of soul or spirit entities reveals the intricate interlocking of beliefs about the moral meaning of the body, the nature of personhood, its survivability, and the eschatologies that give shape to this world and to invisible realities beyond it.

The Living and the Dead

The third relationship in Hertz's model is that between the living and their dead—grief, bereavement, and memory. Like body disposal and soul beliefs, styles of grief are highly variable and one of the more dramatic examples in the anthropological record is that of the Sora, a tribal people in eastern India who have lived there longer than the surrounding Hindu majority. They regularly engage the newly dead in animated postmortem conversations facilitated by female shamans who voice the wishes and especially the complaints of the deceased. There are grievances to settle, and these are aired in lengthy, public dialogues that are painful, sometimes humiliating, and occasionally humorous. The dead can be dangerous if they choose; they can threaten to visit the cause of their demise onto those still living. Eventually, however, over a series of difficult and even raucous encounters, reconciliation is achieved and the dead agree to drop their demands and, to the relief of the living, abandon the conversation.

Although less dramatic, exchanges between the living and dead are common in Western cultures. The long European history of ghosts and frightening hauntings is, as among the Sora, about aggrieved individuals who in death do not go away as they should but remain to pester the living. That threat has been tamed in the contemporary world, but their presence is still evident. Sightings of deceased husbands and other signs of their ghostly nearness are common according to studies of urban widows in the United Kingdom. So too are graveside conversations, even if one sided. The well-known *Día de los Muertos* in Mexico is also an occasion for the dead to return to family and familiar places. As their part in a communal cult of the dead, the living construct home altars decorated with objects (*ofrendas*), mementos once important to the dead, and these can range from food to liquor to books, photographs, and religious icons. Souls are expected each November 2 (All Souls' Day) and are attracted to and appreciate what has been prepared for them. Much more cursory is the North American holiday, Memorial Day, with its brief visits to family graves to tidy them up and leave flowers.

All such practices of remembering in private memory and communal event, or of intentional forgetting as an expression of honorable regard, are instances of a newer way some researchers are conceptualizing grief and mourning. This model emphasizes continuing bonds, the living learning to live with their dead in a new, revised relationship. The Sora illustrate this clearly in that the newly dead have unfinished business; despite the discomfort of their verbal jousts with survivors, when misunderstandings are aired and forgiveness is extended, the ghosts go in peace. This contrasts markedly with the English-speaking world's preference for private, heroic endurance, "grief work," the strategy for promoting "resolution" and "closure" so the living can "move on." The ethnographic record suggests this is not the norm. So too does recent counseling with the parents of deceased children in support groups. In the continuing bonds model, parents are encouraged to cultivate a new, open-ended relationship with their dead child, one that is continuously revised and evolves over the years. Further, this experience of grief is communal, as is true of many cultures where mourning is shared in extended families, gatherings of friends, and in conversations in the village square as among the Sora. The distinctive American preference for privatized grief and gradual exile of the dead from communal awareness is likely associated with the rise of modern individualism, social and economic mobility, and decline in the authority of traditional religious teachings on the afterlife.

Dilemmas of Hospital Dying

The ethnographic examples cited so far suggest the diversity of cultural solutions to a common human problem. More recently, however, anthropologists have shifted their attention to death itself, not simply its aftermath. This has happened because modern medical technology has transformed both dying and death, making them problems to be managed. Newer studies examine the consequences of this shift, using the same ethnographic methods developed in the tradition of field research in exotic locales.

Managed dying is, to a large degree, a matter of timing. Medieval Europeans were familiar with that: Theological tracts called *ars moriendi* used to guide the dying toward a ritually tamed good death. Modern medicine ties dying with life extension technologies. Two critical technologies are mechanical ventilators, derived from the iron lungs

of the 1940s and intensive care units (ICUs), first established in hospitals in the 1950s. Shortly after the introduction of ventilators and ICUs, sociologists and anthropologists began to notice what they called social death, a prolonged liminal state where the dying are neither fully alive nor explicitly dead. They hover in a twilight zone made possible by aggressive medial intervention. When medical staff and visitors speak about the patient in the latter's presence as though he or she is not there, social death is the reality of that moment. It is a peculiarly modern condition defined by the moral ambiguities surrounding aggressive intervention. What, for example, is specifically diagnostic of life, or of death? When is a full technological press to maintain life appropriate? When is it too much? Once started, when should it be stopped and, if so, on whose authority? These are not only questions of law, medical ethics, and hospital policy but also bedside realities for anxious family members having to make difficult choices.

How laypersons react to these challenges is one area of anthropological interest. A hospital, like any corporate community, has a distinctive culture in which visiting laypersons are outsiders to whom much that happens is invisible or incomprehensible. Visitors may not know that treatment for dying patients is more to stabilize than to cure, that prognostication is something doctors avoid or smother with generalizations, and that some physicians are more willing to use all available technology than are others. Nor are ideals such as patient autonomy and informed consent easy to apply. Life is sometimes prolonged even when there are medical doubts about the helpfulness of doing so or when families are in conflict (not uncommon) over what to do next. One anthropologist has described hospital end-of-life care as a zone of indistinction abounding in ambiguities that undermine hopes of a good death or a death with dignity. None of this is intentional; it simply flows from the logic of great medical capability and complex institutional arrangements for managing the barely manageable.

Resolving these untidy matters is normally done in quiet consultations in hallways or doctors' offices. Occasionally they break into public view, where they arouse controversy and passions. That is because medical technology and timing have made possible a new life form: individuals in a persistent vegetative state, maintained by machines and pharmaceuticals. Theirs is the ultimate social death. The numbers are growing, and individuals in such a state challenge conventional beliefs about moral personhood and the role of divine authority at the end of life.

One such individual was Theresa (Terri) Schiavo, whose headstone reads "Departed This Earth February 25, 1990, At Peace March 31, 2005." For 15 years Schiavo's body was a site of political, legal, and religious theater on which the ambiguities of timed dying were played out: her uncertain intent and lack of autonomy in deciding on care; legal challenges as to who could properly make clinical decisions for her; questions as to whether a recognizable self or personality still resided in a socially dead body; acceptable language for her condition, the term *vegetative* thought demeaning by some; and fears that in withdrawing life support, the judgment of flawed mortals is substituted for divine intent. These are not only medical and legal matters but cultural and theological ones too. Because hospitals are where most Americans die, they are the prime venues for competing, contentious views about what is to be done at the end of life and how it is best timed.

A related decision and one usually easier to make is organ donation, the "gift of life." Gift giving is an old interest in anthropology, associated with earlier research on social and economic organization in traditional, kinship-based societies. Organ donation is comparable to exchange in prestate systems in that it is nonmonetary, gifts are anthropomorphized by their association with the giver, and their circulation is part of a moral economy rather than one based on cash. In such systems, no gift is ever unencumbered and purely altruistic. Receivers are under obligation to reciprocate in some way, preferably in the future rather than immediately, making them debtors beholden for the long term to givers.

These themes are evident in modern organ donation as well. The gift of an organ is sometimes fetishized, recipients believing they have inherited behavioral features of their donor (of whom they know little or nothing). These have included newly acquired food preferences and aesthetic tastes in music or art. Some wonder if the donor was morally upright, even criminal, putting them at risk of acting out antisocial proclivities. Others express a desperate need to know all they can about the

donor and the circumstances of death. They want to reciprocate, to "give something back" by doing good works in the name of the deceased. But others are less troubled, adopting the larger culture's view of the body as a kind of machine and their new kidney an "off the shelf" replacement. Organs are utilities, spare parts; this idea fits well with the consumer orientation of American life. In this regard, anthropologists have studied the busy international traffic in organs, and some have voiced ethical objections to the exploitation of donors in poorer countries on behalf of well-to-do recipients in the developed world.

An additional area of current anthropological interest is memory and memorialization. Conventionally, memory is psychological recall, a private experience in the mind. In anthropology, however, it is useful to think of it as something social as well, "memory as moral practice," an insight originating in ethnographic work on suffering in Madagascar. Memory in this model is a narrative recreation that draws its imagery (and hence its veracity) from selected and edited details of past experience. It is put forward, as one anthropologist has said, as a point of view of "back then" from the vantage point of now and of subsequent, intervening lived experience. Memory so understood is a species of storytelling that, as a moral practice, is both artful and strategic. Obituaries, eulogies, and the storylines of Internet memorials or "virtual cemeteries" are examples.

A popular if minor literary genre, obituaries are teaching devices presenting the life of the deceased in reference to contemporary standards of value and worth. (Obituaries for the notorious do this also, representing their subjects as negative exemplars.) For example, newspaper obituaries in the 1800s were most often written for white, propertied men, their endeavors the more valued, and for women if they were associated with important men. Women were typically described in terms of their domesticity, charity, and Christian virtue, whereas men were described in terms of their military, political, or business prominence. The text was florid, with appreciative editorial asides; verbal artistry by the writer was expected and necessary. An obituary was a well-told morality tale. Obituaries now, however, create a memory line according to a very different aesthetic. They read like a job résumé: place of birth, educational and military experience, marriage and offspring, business and professional accomplishments, and, for women whose careers were in the home, their domestic and voluntary interests. Hobbies and late-life travel come near the end of a matter-of-factly rendered life history, followed by brief, conventional references to the sadness of survivors. Private ruminations, of course, are more nuanced but, like an obituary, they replay a storyline that is highly selective and built around an aesthetic appropriate to a time and place. Memory as moral practice gives shape to the past (aside from what actually happened); helps justify action and judgments in the present; and affirms that, in recall, the dead are still with us and can never be completely gone.

The various topics reviewed here do not exhaust the ways anthropologists study death, but they suggest the range of interests. A topic for future research, oddly overlooked so far, is ethnic and cultural diversity in end-of-life care. Some important beginnings have been made, but they tend to be abbreviated case studies with little in the way of cultural context. More than that will be needed. Anthropologists will undoubtedly respond with full-scale, nuanced studies comparable to those of earlier ethnographers.

James W. Green

See also Bioethics, History of; Body Disposition; Eschatology; Memorials; Soul

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Death, Clinical Perspectives

The clinical perspective of death involves the person, as a whole, dying. From the perspective of physiology there are many ways to die, and there are many physiological ways to describe the death of a body. But any discussion of the clinical perspective of death should never be limited to these physiological aspects of death because the clinician is concerned with persons, not merely with bodies.

Many variables affect the manifestation and progression of death in different people. From the clinical perspective there are many ways in which, even without the pursuit of "cure" physicians and other caregivers attend to a person as dying progresses—maintaining their integrity as a person, their intimate relationships, the viability of attainable goals, and the maximum joy with minimal suffering each day, and toward the end, each hour. To adequately respond in this way, it is useful to know particulars about the person who is dying. The fears that often attend the process of dying can lead to great suffering. These fears can be of many different types. The clinician, who must understand the physiological aspects of the dying process and who must be able to manage the physical symptoms that can afflict a person who is dying, must also pay attention to the particularities of an individual person's experience of dying, including their fears and their hopes for whatever time remains. This is not the same as discussing issues of pain medicine dosing, survival data, and other quantitative information. And yet, awareness of a patient's fears can drastically change the way the clinician weighs the many options available for intervention and the way he or she presents the options.

In addition to this, often people die in the context of families who will affect the person's experience of death and who will be left standing by the bedside after the patient has died. Long-term medical care typically involves a small set of people—often only the patient and a spouse, friend, or parent. But at the time of death, many who are important to the patient will arrive at the bedside. The work a patient and a close friend have done over time to get ready for death may not have been done by extended family and friends. In such crucial hours questions may arise from new arrivals that seem not to mesh well with the clinician's experience of the patient and the most intimate associates. And yet, the clinician must remember that the extended family and friends, whatever their views, play a role in the patient's experience of life and death that simply cannot be fathomed in a short period of time. These aspects of the end of life are important in fully understanding the clinical perspectives of death. But again, for many clinicians, they are the hardest to fully understand, especially as they are not always emphasized in the education of clinicians.

A Three-Step Process Perspective on Dying

There are three steps that a clinician can take to gain a fuller, more adequate perspective when caring for a dying patient. The three steps are relationship, negotiation, and the establishment of a plan.

Relationship

The first step, relationship, involves three important aspects. The initial aspect is understanding the illness experience. Until we understand the details of a particular person's experience of dying and of being ill, it is impossible to respond to the full reality of the unique experience that particular person is having. Even the physiological aspects of death cannot be responded to adequately until we understand the special experience of that person. Central to understanding the illness experience is listening, which can be difficult when a patient is suffering or dying. The most useful listening often involves things as simple as allowing the patient to suggest what they perceive to be of most benefit to them in the context of their illness experience. In the current atmosphere of medicine, this subjective element in decision making does not always fit more common criteria for decision making—your appendix is inflamed, so it ought to come out; you have pneumonia, so you ought to have an antibiotic; you have a curable cancer, so you ought to have chemotherapy; and sometimes, you have an incurable cancer, but you ought to have chemotherapy because we give chemotherapy to people who have cancer. However, at the end of life, the most important elements do not fit into the same category as appendicitis, pneumonia, and cancer. What the suffering person says about his or her

suffering is itself the instrument for determining the best course of action—every bit as much as a blood culture is the proper instrument for determining the cause of bacteremia and the proper antibiotic for the disease.

The second aspect of the relationship step is sharing relevant information. To make good decisions about particular lives—whether it is the decision of an ill person, that of a spouse, or that of a parent for a child—adequate information is necessary. This information may include such things as the nature of the disease from which a patient is dying, the likely course and timing of a death, and the processes in place in the clinic or hospital for managing patients who are dying. However, many people who are dying do not want to know the details of their disease, the timing of their disease, the likely manner of death, or even the inevitability of their death. Indeed, for some people, ignoring the inevitable seems to be part of their quality of life during their final days. This can be culturally based (in cultures as diverse as that of Brazil and that of Japan, the reality of fatal illness is often not revealed to the ill). But within any culture, irrespective of "cultural norms," there are people who do not wish to know the details of their fatal illness. There is no moral imperative for ensuring that everyone who dies does so knowing the cause of their impending death, nor even that they are dying. There is, however, a likely moral imperative for the clinician to make sure he or she knows to whom he or she is talking as far as possible, because this knowledge can make available windows of opportunity for the dying that might otherwise be missed. Unfortunately, sometimes clinicians stay silent about death because of their own discomfort. Responding to dying patients is indeed among the hardest aspects of being a clinician.

A third aspect of the relationship stage is a global needs assessment from which it is recognized that the needs of people who face of death vary widely. Some will tolerate much more pain than others in exchange for mental lucidity. Others will have fear of pain as their primary source of anxiety. Some will be profoundly affected by fatigue, others by depression, others by concern over their appearance as they become cachectic or edematous. Global needs assessment is a process of asking questions and of listening without presumption of what a particular person's needs may be. Stating needs can be difficult, especially for patients who have long been self-sufficient. Finding the language to characterize the needs is difficult—suffering at the end of life often has the character of vagueness, despite being deeply important to the experience of well-being.

Negotiation

The second step in comprehensive care of a dying patient is the step of negotiation, which also involves three aspects. First is a discussion of the prognosis. Again, the amount of information shared regarding prognosis may depend upon the person's own expressed desire to know, as well as factors such as culture and family wishes. But culture and family wishes should never determine, a priori or presumptively, how much the patient wants to know about prognosis. Only the individual can reveal explicitly or through hints and suggestions how much he or she wishes to know about prognosis. Another important point is that patients are often interested not only in the prognosis regarding the likelihood they can be cured, but also in the likelihood that in the face of incurable disease their suffering will be controlled, or that the disease can be slowed sufficiently to enable them to experience additional good days, weeks, or months. This latter aspect of "prognosis" for a dying patient can have implications that are more immediately pressing than any other, for this aspect provides the dying person a measure by which they can determine what they might hope for and what they might concretely achieve. The window of opportunity for such hope and achievement is often so limited at the end of life that the clinician should feel an urgency about determining what the patient wishes to know in terms of prognosis.

The second aspect of the negotiation stage concerns goals. At each juncture in the process of dying, whether long or short, when an intervention or decision is being considered, it is vital that it be considered in light of some goal—whether the goal concerns some aspect of suffering, a physical act to be accomplished, or reconciliation or forgiveness. Discussion about goals disciplines and focuses decision making in any clinical arena, but especially in the clinical arena of the dying person. Without discussion of goals, unnecessarily burdensome interventions can be made that truncate

possibilities for achieving goals. Here, as in every other domain of the decision-making process, one cannot presume what goals may look like for people who are dying. It is easy enough in the clinical arena to presume that goals would be related to things achievable by medicine. However, the obligation of clinical medicine is to remain open to surprise by an individual patient's perspective and wishes.

The third aspect of negotiation, after discussing prognosis and goals, is the consideration of options. The good clinician will be as prepared as possible to offer options in the face of goals and prognosis. This is a matter of training and conscientious attention to advances made that might benefit the patient. At the same time, the good clinician will acknowledge when he or she is not certain of the options. In such a case, the clinician can offer enormous benefit to the patient and the family by being an honest guide in the search for options that fit the patient's goals set in light of the patient's prognosis. Humility in the face of uncertainty is one hallmark of the great clinician in the arena of death, and it can lead to deep and abiding benefit for a patient and family.

Establishing a Plan

The third step in developing a comprehensive approach to the dying patient is establishment of a plan. Having become acquainted with a particular person's understanding of the illness experience and of his or her needs and having discussed relevant information (including information about prognosis and information about the patient's goals and options for moving forward), both the medical plan and the life plan will come together in a comprehensive plan. This comprehensive plan is always susceptible to change as either goals or prognosis or options change. Indeed, the fact that a plan can change if a patient's status changes can be a source of deep and meaningful hope for a person in the middle of suffering. Many experienced clinicians have seen enough unexpected improvements at what was thought to be the end of life that this openness to surprise is neither unreasonable nor deceptive. But the value of a comprehensive plan in the clinical setting is that windows of opportunity for achieving goals are not lost on the presumption that medical interventions are most beneficial to a person.

The Patient–Clinician Relationship

One important reason for the flexibility of the comprehensive plan is the fact that there is often uncertainty in the period surrounding death. This uncertainty about death is something shared by both the patient and the physician, and this fact is often not explicit in the relationship between clinician and patient. Nonetheless, it is an important aspect of the reality of the patient–clinician relationship at the end of a patient's life, whether or not it is acknowledged.

Though decisions are often made in the face of uncertainty, those made at the end of life are sometimes more uncertain than others. But certain types of healing are uniquely possible in this setting. Here, relationships are crucial.

The healing aspects of a physician who is willing to stay with the patient, to listen, and to make available options that help the patient to achieve goals in the final stage of life cannot be underestimated. This relationship between the doctor and the person is one of the most important aspects of the clinical perspective on death. A part of it is simply being with someone who is experienced with people who are dying. For the clinician, the temptation is to run away and distance oneself, or else to move so close that the experience becomes an authentic experience of "the death of a person" but thereby becomes so intense (especially if repeated) that the situation is not sustainable in a way that allows the clinician to maintain a healthy perspective. This leads to suffering on the part of the clinician that can evolve into burnout, eventual emotional coldness for the sake of protection, or unhealthy behaviors that offer escape through addiction, broken relationships, or suicide.

Responding to Questions

Another important aspect of the relationship between clinician and patient is simply being with someone who is willing to live with uncertainty and to ask questions such as, "When are you actually dying?" in a society that tends to hide the realities of death. When does the dying process start? This is not merely a question of physiology. Dying is a process that precedes death. But only death fully accomplished has a clear demarcation. The process of dying is a gray area, one that

evolves, one that can simply dawn upon one over time. And here is another aspect of the clinician's role in helping the person toward death: There is much that can be done to ease the burden of symptoms and to restore function so that the active process of dying is still in the future. This is not an effort to avoid death but rather an effort to treat persons who are experiencing the illness of dying. Though death cannot be stopped, the illness of dying can often be treated in such a way as to alleviate many of the aspects of suffering associated with death.

The Caregiver Team

Another important aspect of the clinical perspective on death is it involves more than the patient who is dying. A person's death is profoundly affected by the presence or absence of family members, both for better and for worse, depending upon the particular circumstances. But in these cases, the role of the medical caregiver is special because the medical caregiver attends the death, attends the person who is dying. One important aspect of this attending is restoring relationships as far as possible. The centerpiece of the clinical management and response to a person who is dying is relationship. The clinician's relationship to the patient and the relationship of the patient to other members of the care team are all centered upon treating the illness of dying, reducing the burden of symptoms, and facilitating the renewal and the ongoing integrity of a person's relationship with those around him or her. This aspect of relationship is central to the clinical perspective on dying, and even medical interventions such as the relief of the burden of symptoms and the restoration of function are performed with the goal of maintaining the integrity of relationships.

Effect on the Clinician

One last but no less important aspect of the clinical perspective on death is the effect of death on the clinician as a person. If the relationship of the clinician to the patient is central in this clinical perspective, the fact that the clinician is a person is central as well. Because the clinician attends hundreds or thousands of deaths in a career, he or she will change over time. Over time, he or she will gain facility, nerve, calmness, knowledge, capacity, and the ability to function with confidence while the dying person will have a singular experience, namely, their own death. The clinician's relationship with dying patients will be affected profoundly by how they negotiate their own experience of mortality. This aspect of clinical perspectives on death and dying is one that is insufficiently discussed in contemporary medical education.

Summation

In summary, the clinical perspective on death has no single descriptor but is as fluid and responsive as the range of people who die. Pathophysiology will be affected by the social, cultural, spiritual, and family aspects of the dying process. The dying process itself will be influenced by many of these factors, and the start of the dying process may be different from one person to another despite the apparently identical physiological processes. The clinician who is privileged to attend persons at the time of their dying must pay attention not only to the physiological realities at hand but also to other potential sources of suffering, and he or she must help to make explicit the goals, options, and opportunities at hand. Central to the clinical perspective on death is relationship; this includes the relationship of the clinician to the patient and also the ways in which the mature clinician can facilitate and enable the patient's relationships with those around him or her. In addition, the clinician armed with knowledge of such things as interventions to reduce the burden of symptoms can, in many cases, effect healing even when cure is not possible. Healing can occur even in the middle of the dying process. There are many things that can be done to maintain the integrity of relationships and the wholeness of the dying person, and when death is more clearly certain and imminent, the clinician does well to provide this opportunity to a dying person. The goal of the full clinical perspective on death is to put at the service of persons the wealth of possibilities in medical science with the aim of wholeness, integrity, and fullness of relationship. When a person dies, it is crucial for the clinician to remember that there are people left at the bedside, including family members and friends, as well as staff, some of whom may be

profoundly affected by seeing death for the first time, others of whom need to be reminded that no death is just a death but that every death is a singular event. The grief and bereavement of all people involved are among the most important aspects of the clinical perspective on death.

Raymond Barfield

See also Appropriate Death; Caregiving; Halo Nurses Program; Hospice, Contemporary; Palliative Care

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Death, Humanistic Perspectives

Death is a biological phenomenon: All living organisms die. Biology, medicine, and other disciplines examine death scientifically. However, death is also a human phenomenon investigated by the human sciences, such as cultural anthropology, history, religious studies, and literary theory, as well as social sciences, such as sociology or sociopsychology. Philosophical perspectives on death constitute an important class of these humanistic perspectives.

This entry discusses the humanistic perspectives on death by drawing attention to the difference between *naturalistic* and *humanistic* approaches to human nature in general, and to death as a key aspect of human existence. First, this contrast is described in broad terms. The humanistic perspectives on death are then divided into three: *essentialist*, *existentialist*, and *culturalist*. The distinctions between these are based on general philosophical anthropology (the philosophical study of human nature), providing helpful categorizations across the humanistic disciplines. Another subdivision is the one between *empirical* and *conceptual* approaches to death. It is the task of philosophers to contribute to conceptual investigations of death and mortality, while others in the human sciences explore these issues on empirical grounds.

Humanistic and Naturalistic Perspectives

Naturalist accounts of human existence, including death, emphasize that human beings are natural creatures among other animals. They are not essentially different from other organisms, although their skills and capacities exceed those of animals. Naturalism arises from the advancement of the sciences in the modern age. From a scientific perspective, human beings occupy their distinctive place in the world simply as natural beings. They do not have any special "task" or purpose (*telos*) beyond itself. Scientists observe human life and death from an objective, third-person point of view, describing and explaining facts about how people live and die. Death, then, is not essentially different from, or more mysterious than, any other natural phenomenon. It is part of nature. If it is natural to live, it is natural to die. Science can describe and explain all the facts about death and dying that are explainable.

According to naturalism, there is no immortal soul (or its equivalents, as conceptualized in different religious traditions). There is nothing to seriously qualify as the subject that could survive death; the very idea of survival, immortality, must be rejected as unscientific. Death is the final, irreversible cessation of the processes of life. This kind of naturalism, or materialism, is the paradigm not only of science but of recent analytic philosophy of death, defining the context within which it is examined, for instance, whether or not death is bad for the one who dies—a question originally discussed by the ancient atomist Epicurus and his followers, especially Lucretius. (Yet, there are also analytic philosophers, such as Richard Swinburne, who defend dualistic and Christian ideas of immortality.)

From a more humanistic perspective, however, a reductive naturalist picture of humanity, including death and the experience of death, remains unsatisfying. For most people, death is something "more"—more mysterious and terrifying—than ordinary natural phenomena. Even those who deny the existence of supernatural beings (such as deities) or survival after death may find the naturalist perspective on death too restrictive. One need not adopt pseudoscientific beliefs about any "afterlife" in order to maintain that a natural-scientific treatment of human mortality is insufficient.

Humanistic perspectives on death receive part of their motivation from the inadequacy of the purely scientific perspective, which, despite its enormous significance for understanding death as a biological event, fails to appreciate its human significance.

Whereas biologists and other natural scientists investigate death as the natural termination of life processes, researchers in disciplines like cultural anthropology or history may examine how death has been conceptualized in different cultures. Literary theorists and critics, as well as art historians and others in the human sciences studying art, may discuss the depictions of death in literature, the fine arts, and the cinema. Such perspectives on death focus on what death or mortality—or beliefs about immortality—mean or have meant for people, instead of describing and explaining mere natural facts.

Three Humanistic Perspectives

Humanistic perspectives on death may be classified in terms of the underlying conceptions of humanity they assume. When applied to death and mortality, this philosophical anthropology turns into philosophical thanatology, which, as a philosophical subdiscipline, amounts to a largely nonempirical inquiry into mortality and its significance for life. Such an approach to death is distinguished from empirical inquiries seeking answers to factual, explanatory questions, whether natural-scientific or historical and social-scientific. Philosophical thanatologists may also study death in a general conceptual way not restricted to humans. The meaning of the concept of death may be distinguished from the observable criteria of death. It is one thing to determine whether an organism is dead; it is another thing to say what its being dead amounts to. Such conceptual problems may have an influence on how philosophers and social theorists think about such concrete cases as the ethics of abortion or euthanasia.

One should also distinguish between death as a state (being dead) and death as the event of an entity's entering that state. Moreover, death and dying must be distinguished: One may not fear death (being dead), because if death is the end of experiencing, there is nothing to fear, as nothing harmful can be experienced if there are no experiences; yet, one may fear the possibly painful process of dying, the process irreversibly leading to the state of death. This process itself calls for conceptual clarification. It would be misleading to identify it with life, although all living beings, with natural necessity, die, and their entire lives could be seen as processes inevitably leading to their deaths.

In addition to these conceptual distinctions, three major humanistic perspectives on death may be distinguished: (1) essentialism, (2) existentialism, and (3) culturalism. These will first be described in general terms and then applied to death.

Essentialism

Essentialists attempt to reveal an immutable essence of humanity, the necessary and sufficient ("essential") properties that make human beings humans, separating them from the rest of the world. Plato, Aristotle, and classical Christian thinkers were essentialists. The human essence, "human nature" in the essentialist sense, is *normative:* It not only describes what kind of beings humans are but also prescribes them to be as fully human as they can, to fulfill their essence. The essence of humanity is not simply a matter of facts but also a matter of what humans ought to be, as elements of a cosmic, normatively structured "world order." Naturalists argue that there is no such "order" at all but only the natural, factual world order. From a scientific perspective, human beings' place in the world among other natural entities is not normatively distinguished. The kind of objective normativity defining human nature in an Aristotelian or Christian essentialist fashion lacks scientific justification. Thus, naturalism, as described here, abandons essentialism.

Existentialism

Existentialism is another way of "negating" essentialism's search for a universal human nature. Instead of "factualizing" (with naturalism) the normative order that essentialists regard as objective, existentialists deny that human beings are bound by *any* such order, natural or normative. Existentialists do not claim that people are free to breach the laws of nature, but they argue that the subject is radically free to (re)interpret his or her own situation. According to Jean-Paul Sartre, in particular, the subject finds itself "thrown into the

world" amid natural and political contingencies, especially the absurdity of death, but in this situation it is precisely up to himself or herself to create meaning in life. No prior order, either normative or factual, constrains the subject's constructions. There is no essence—no timeless image—of what human beings inherently are. The world itself, just like the subjective life thrown into it, is objectively absurd; the individual is responsible for creating any significance life might have. Celebrating the autonomy and responsibility of the subject, existentialism opposes the naturalistic tendency to see people as ultimately mere bits of matter. Sartre also opposes the essentialists' urge for an essence prior to individual existence. There are major divergences between Sartrean atheist existentialism and Christian forms of existentialism (e.g., that of Paul Tillich or Gabriel Marcel), but the emphasis on the significance of individual existential situations unites these different views.

Culturalism

Culturalism can be seen as a synthesis of all the other types of philosophical anthropology. According to culturalists, human existence is irreducibly cultural and sociohistorical. People live within a normative cultural framework constitutive of their humanity. Culturalists sympathize with the essentialist search for normative characteristics of human nature, but they have learned from naturalism and existentialism that this search cannot be satisfied in its traditional form. It is, however, difficult to follow naturalism to the reduction of human beings to mere material objects, or existentialism to the affirmation that humans are free without limits and that no basic characteristics of humanity—no prior normative order—is needed. Avoiding these extremes, culturalists affirm that people live within a normative order constructed (and reconstructed) by human beings themselves—not as individuals but as sociocultural beings within their practices. No ready-made, cosmic, normative structure sets a model to how human life should be led in order to qualify as human; nor can humans live without any such normative order. Rather, the human world is a cultural world.

Applying these three general perspectives to death and mortality, the following humanistic perspectives emerge:

Essentialist accounts of death, especially Christianity and other religious views on humanity, traditionally postulate an immortal soul or spirit, though not all religious defenses of immortality are essentialist, and not all forms of essentialism postulate an immortal soul. Even though the body is destroyed in death, the person's essence, the immortal soul, will live on. The conceptual basis of such a view is something like Cartesian mind–body dualism. Alternatively, if the inseparability of body and soul is emphasized, as in traditional Christianity, one may claim that the entire person will be resurrected on the "last day." For Plato, in contrast, the essence of humanity was the supersensible reason. In any case, it is the immaterial, immortal soul—however it is conceived in detail—the highest "level" of a person, that is taken to be in touch with the normative world order central to essentialist theories. Whether a person deserves salvation depends on the moral quality of his or her life.

Existentialist views, more strongly than others, emphasize the significance of mortality for understanding human existence in general. This is famously captured in Martin Heidegger's notion of "being-toward-death" (*Sein-zum-Tode*) and the related pursuit of authenticity (with its roots in earlier protoexistentialists, including Søren Kierkegaard). Existentialists focus on the individual, personal nature of death: One can only live one's own life and face one's own death. The full acknowledgment of this is the only route to authenticity. If one refuses to acknowledge the deeply individual nature of one's mortality, one is leading the life of what Heidegger called *das Man*, the anonymous, inauthentic subject. Existentialism, in its Heideggerian form, also maintains that only human beings *can* die. Only humans are mortals, whereas other living beings just perish, cease to exist; their mode of being is not "being-toward-death." Death, existentialistically viewed, is closely related to the absurdity of life and the world as a whole. Death itself is the ultimate absurdity, to the extent that an individual may, like the person described in Tolstoy's *The Death of Ivan Ilyich*, be unable to accept the fact of his or her own death.

Culturalists understand death and mortality (and the possible search for immortality, often in religious contexts) as sociocultural phenomena, describable, explainable, and understandable from

the standpoint of empirical anthropological and/or cultural-historical studies on the significance of death and related rituals in various cultures and historical epochs. Philosophically, culturalism thematizes mortality as part of the "order" people create and (re)structure, as part of their symbolically articulated self-understanding of their lives as mortal—a self-understanding that is, in most cultures to some extent, religiously manifested and transmitted. Living in the "human world," human beings live a mortal life. This is part of the cultural normative framework they set for themselves; natural-scientific investigations of death, though abstracted from specific cultural contexts, are parts of this same cultural framework. Culturalists need not claim that the fact that humans die is "culturally relative" (in an implausible factual, empirical sense), as if there were exotic cultures whose members were immortal. Rather, culturalists view mortality as a biologically based phenomenon that needs to be received and interpreted in all cultures recognizable as human. In this sense, it resembles other deep features of life, such as birth, parenthood, or sexuality.

These applications of different conceptions of human nature to mortality are hardly ever represented in pure forms. There is enormous variation in the ways in which philosophers and other scholars view death and mortality; the ideal types distinguished in this entry reflect only some of the basic differences among humanistic perspectives on death.

Open Issues and Challenges

To further enrich those perspectives, the following *challenges* to the humanistic understanding of death and mortality can be raised.

First, the subjective, individual, personal nature of death—the primacy, for any "I," of *my* death in comparison to anyone else's—cannot be overlooked. Humanistic reflections on death and dying ought to take seriously this inevitability of a first-person standpoint. The contrast between existentialism and culturalism—and the aspects of mortality they emphasize—is crucial here. It is a key existentialist point that only one's own death can be authentically faced. The question arises whether the existentialist, viewing death and mortality as "one's own business," irreducibly first-personal, can adequately acknowledge the mortal "Other." Because of its *solipsistic* tendencies, existentialist philosophical thanatology tends to be narrow, recognizing only one aspect of human mortality. If death is simply "one's own business," it is unclear how to decide, objectively, whether an individual succeeds or fails in authentically facing his or her mortality.

Secondly, immortality seems to be passé, given the overwhelming evidence there is for a (broadly) naturalistic picture of life and death. One of the few philosophical legitimations for this idea still taken seriously is Immanuel Kant's defense of the immortality of the soul as a "postulate of practical reason." Furthermore, one may ask whether immortality should be approached from a subjective (existentialist) or culturalist perspective, given that essentialist accounts of survival are nonstarters. If the hope for and the possibility of immortality are reduced to facts about how these problems are viewed in different cultures, philosophical thanatology will, however, be reduced to its empirical counterpart. Normative, especially ethical questions emerge, however, as soon as it is realized that immortality is not only a metaphysical problem about there being an immortal soul but also the moral problem of whether a certain kind of life, or (metaphorically) a certain kind of "soul," could be seen as "entitled to," say, the immortality some religions promise.

Thirdly, one may ask whether culturalism, either generally or in its thanatological applications, entails cultural relativism: Is there any objective truth, scientific or otherwise, about cultural phenomena or culturally interpreted natural phenomena (such as death)? Cultural relativism, as an apparently natural outcome of culturalist reflections on human existence as tied to culturally established normative frameworks, threatens to "refactualize" the normative order that culturalism sought to re-erect on the ruins of essentialism that the naturalist "factualization" of essentialism's original normative (cosmic) world order left. If the cultural framework structuring the "human world" people live in is just contingently established and maintained within a particular culture, it is hardly truly normatively binding. Culturalism threatens to collapse into naturalism, if naturalism is understood broadly as the replacement of a normative world order by a contingent, factual one. In

the case of mortality, the result is a replacement of the ethical issues about how to lead a mortal life by the factual question of how those issues have been articulated in various cultures or societies. Mortality as a personally serious problem will then be lost, philosophical thanatology abolished, and the humanistic perspectives on death impoverished.

Fourthly, death requires not only metaphysical, epistemological, or conceptual but also ethical attention. One might even suggest that human mortality is a topic whose metaphysical and ethical aspects are intimately, inseparably entangled with each other. It is impossible, for mortals, to inquire into the significance of the concept of mortality without taking an ethical stance to the question of what it is to lead a decent life as a mortal being with other mortals. There is no prior metaphysical question of what death "is" and no prior semantic question of what the relevant expressions mean. Rather, the ethical issue of how to face mortality is ipso facto a metaphysical one, expressing the full human meaning of mortality, "existentially" viewed. This suggestion is opposed to the orthodoxy of analytic philosophical thanatology, according to which the metaphysics of death must be settled first, before turning to ethical questions.

Finally, one might wonder how different philosophical and humanistic background ideas affect one's views on such special cases of death as abortion, euthanasia, murder, suicide, capital punishment, and war death. One general remark is in order. The point is not that one can, or should, first develop a general humanistic perspective on death and only then apply it to such cases. On the contrary, one's preunderstanding of these cases, as profoundly ethical situations of human death, inevitably contributes to one's ability to pose and respond to the metaphysical challenges that, conversely, contribute to one's understanding of the "cases" themselves. One might, for example, be convinced that murder is always wrong. With this moral conviction in place, one might go on to examine what one takes to be central philosophical or general humanistic questions about mortality. In such an examination, one's ethical convictions would not need to be bracketed; instead, one might bring all relevant factors into the holistic discussion of both factual and normative statements and hypotheses relevant to the phenomena examined.

A pluralistic account of the different humanistic perspectives yielding diverse philosophical issues about human death may offer more promising tools for investigating death and mortality than will standard conceptualizations, many of which are too narrow to deal with these issues in a manner adequate to their human complexity. Death has several aspects, manifested in the different perspectives from which it can be viewed. This is *not* to say that narrower conceptualizations, such as analytic arguments regarding the definition of death, are unimportant in their own contexts. Nor should the importance of empirical work within cultural anthropology, history, or medicine be underemphasized. However, human mortality is a holistic phenomenon, accommodating features from various humanistic fields, as emphasized in the different ideal types of philosophical anthropology. The relevant context for a humanistic reflection on death is not an imagined "context without context," a transcendent "God's-eye view," from which one should determine what death really is. To reflect on death from within human life, as partly defined by its mortality, is to reflect on the conditions that must be in place for such a reflection to be itself possible. Whatever one's particular humanistic (or naturalistic) perspective on death is, it is only in and through mortal life itself that one can examine this life with full seriousness.

Sami Pihlström

See also Death, Anthropological Perspectives; Depictions of Death in the Television and Movies; Language of Death; Literary Depictions of Death; Mythology; Social Functions of Death, Cross-Cultural Perspectives

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Death, Line of Duty

By definition a line of duty death (LODD) occurs whenever a public safety officer dies while performing work-related functions, whether on or off duty. The term *public safety officer* includes sworn law enforcement, firefighters, and officially recognized public employees of a rescue or ambulance crew. Each death is a tragedy for the victim's family, friends, and coworkers, and each death is a public loss mourned by the community. The significance of their respective roles in the community was perhaps best demonstrated on September 11, 2001, when 72 police officers and 345 firefighters summoned to the New York City World Trade Center died while attempting rescue. This entry overviews LODD, describes its impact on survivors, and discusses the healing process.

LODD Overview

The first known law enforcement death occurred in New York City in 1792. Since that time more than 18,000 police officers have died while in the performance of public service. On average, a law enforcement officer is killed every 53 hours. In memory their names are engraved on the National Law Enforcement Officers Memorial in Washington, D.C. These public servants are honored each May during National Police Week with flags flown at half staff and a national memorial service on the lawn of the Capitol Building. Surviving family members and coworkers attend workshops during the week sponsored by Concerns of Police Survivors, a nonprofit survivor support organization founded in 1984.

An average of 105 U.S. firefighters die each year in the line of duty. They also are honored at an annual conference held in Emmitsburg, Maryland, home of the National Firefighters Monument. Plaques encircling the monument contain the names of over 3,000 men and women who have died while on duty since 1981. The National Fallen Firefighters Foundation created by Congress in 1992 offers a Survivors Network that provides resources and support to the families of these firefighters.

Impact on Survivors

Family, friends, and coworkers are traumatized by the unexpected violence that accompanies a line of duty death, and most often there is no chance to say good-bye. How survivors are notified of the death has a long-term impact on their grief. Thus, each death notification should be conducted in person (not on the phone), with more than one notifier present, and the information should be delivered in plain language and offered with compassion. It is critical that agencies create specific notification procedures and maintain accurate, up-to-date records of the next of kin. Unfortunately many agencies do not have these in place when tragedy strikes, and this can lead to inappropriate notification being made and confusion about how to assist survivors.

The grief and trauma that a line of duty death brings requires survivors to adapt to a new life as they learn what helps and what hinders their healing. Survivors of felonious death can suffer secondary injury when attending lengthy court proceedings, and in the end they may feel justice is not done. The word *closure* is sometimes used inappropriately to indicate an end of grieving; in reality, when a court case is completed, families do not experience an end to their grief. They now must redirect their energy toward developing a new life without their loved one.

Among surviving children, the grief process is especially long and protracted. These children often "numb out," sometimes to protect other family members. For most children, the real processing work of grief may be delayed as long as 5 to 10 years. In this area, C.O.P.S. (Concerns of Police Survivors) activities, sponsored on behalf of children, teens, and adult offspring of fallen officers, provide a safe place to allow feelings to surface and to interact with others who share the same type of loss.

It is common for survivors to feel overwhelmed and to experience fear related to diminished mental acuity and physical exhaustion. The severity of grief experienced is normal given the type of loss involved. Some survivors may contemplate suicide when they believe they are unable to cope with the many changes in their life and as they yearn to join their loved one in death. One study reported the most prevalent and acute symptoms of 126 law enforcement survivors who had been bereaved 10 to 15 years (see Table 1). Fifty-nine percent met the criteria for post-traumatic stress disorder (PTSD). A second study of 298 survivors conducted a decade later reported that 32% of the survivors met the same PTSD diagnostic criteria.

Survivor needs for support are wide-ranging, and survivors often look to their loved one's agency for help. Table 2 contrasts the progress agencies are making in providing support to survivors of loved ones killed in the line of duty. Both studies noted a significant connection between appropriate death notification with adequate ongoing support and how well survivors adapt to their loss.

Research also has identified myths that can have a negative impact on survivors. Survivors are often told that they will always be part of the law enforcement family. In reality, most agencies provide support only for a limited time. Survivors' needs for emotional support also may go unrecognized because of the unfounded institutional belief that knowing the risks involved in providing

Table 1 Most Prevalent and Acute Symptoms Identified by Survivors

Symptom	*Percentage Reporting*
Feeling lonely	75.2
Feeling unhappy or sad	70.4
Feeling low in energy or slowed down	68.3
Feeling easily annoyed or irritated	67.5
Feeling tense or keyed up	66.7
Easily hurt feelings	64.3
Trouble concentrating	56.3
Repeated images that won't leave your mind	53.9
Thinking about the same thing repeatedly	52.8
Trouble remembering things	52.4
Feeling emotionally numb or empty	52.4
Feeling angry	51.6
Wishing others would care for you	51.2
Difficulty falling asleep	50.8
Feeling uncomfortable in social situations	50.8
Feeling people will take advantage of you	50.8
Difficulty making decisions	47.6
Having to think carefully to make the correct decisions	46.8
Being angry at yourself for not accomplishing more	49.6

Sources: Stillman, F. A. (1997). *Line-of-duty deaths: Survivor and departmental responses.* Grant #89-PS-CX0001, National Institute of Justice, U.S. Department of Justice. Symptom levels established by the Derogatis Symptom Inventory, Copyright 1982, Leonard R. Derogatis, PhD.

Table 2 LODD (Line-of-Duty Death) Services Provided by Police Agencies

Service Provided	*Percentage of Police Agencies Providing This Service (1987)*	*Percentage of Police Agencies Providing This Service (1997)*
Hospital expenses	*	40
Death notification	50	80
Funeral arrangements	53	69
Funeral expenses	33	30
Explanation of death benefits	89	82
Escort to the hospital	*	95
Assist with media	92	85
Escort for funeral, burial	95	95
Assistance with insurance	80	80
Financial counseling	32	28
Access to staff psychologist	31	32
Referral to psychologist	43	39
Access to police chaplain	*	67
Aftercare of survivors	*	53
Payment for counseling	*	27

Source: Violanti, J. M. (1997). *Line-of-duty deaths: Survivor responses and departmental Policies.* Grant #98-MU-MUJ-0002, National Institute of Justice, U.S. Department of Justice.

* Not questioned in 1987 study.

public safety somehow prepares families for the death of their loved one. In reality, no one is really prepared to lose a loved one. And while many survivors take comfort in a continuing relationship with their loved one's coworkers, some are prone to hold resentments against the former employer agency if their expectations for support are not met or if such support is suddenly withdrawn.

LODD Healing Process

Peer support is especially important in the healing process. Each year the C.O.P.S. survivor conference provides specific workshops and networking opportunities for survivors. C.O.P.S. also offers week-long retreats that allow survivors to discuss their grief and learn from others who experienced a similar loss. There are separate retreats for surviving widows, bereaved parents, siblings, teens, children, in-laws, significant others, and law enforcement coworkers. Surviving firefighter family members are provided similar services through the National Fallen Firefighters Foundation. LODD survivors also receive financial death benefits through the Public Safety Officers' Benefits Program, administered by the Department of Justice. Financial benefits are crucial for surviving families, but such benefits can also be the source of conflict among various family members.

Surviving coworkers experience grief and trauma at the same time they attempt to assist the surviving family members. Some coworkers eventually sever their contact with the family in order to continue their work-related functions. Coworkers may experience ongoing trauma symptoms and may not have access to or take advantage of psychological support. One study found that 70% of officers involved in a critical incident leave police work within 5 years of the episode. Thus, debriefing and appropriate counseling are essential for LODD coworkers, many of whom can be plagued by survivor guilt and self-blame. There is a need to validate and ventilate such feelings and confront one's own vulnerability in a safe, confidential environment.

Coworkers can develop symptoms of PTSD or be traumatized in ways that eventually affect their job performance and their home life. In general, public safety officers are action-oriented problem

solvers who resist admitting their symptoms, sometimes because they fear doing so will negatively affect their career. Others may feel that talking about their trauma is too painful or too passive. In reality, talking about the tragedy is taking appropriate action to work through the pain and integrate what happened with other aspects of their reality.

If given appropriate support for as long as it takes to absorb and adapt to the death, many LODD survivors eventually find they are not just healing, they also see ways in which they are growing. This does not mean they will ever forget their loved one or what happened; it means they have built up enough "scar tissue" that their symptoms are less intense and more manageable. One study of more than 1,000 law enforcement survivors, bereaved for an average of 9.7 years, explored posttraumatic growth. It reported a strong positive correlation between survivors who participated in C.O.P.S.-sponsored activities and levels of posttraumatic growth. Those survivors who learn from their experiences, such as being a successful single parent, developing public speaking skills, or volunteering to help others, were reported to find more meaning in life and experience lower levels of stress. As survivors work through their grief and trauma in positive ways, they know they are honoring and reflecting the values and courage of their loved one who was so dedicated to public service.

Kay Talbot

See also Coping With the Loss of Loved Ones; Death Notification Process; Prolonged Grief Disorder; Psychache; Transcending Death

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Death, Philosophical Perspectives

The history of Western philosophy is framed by bold assertions on the relationship between philosophy and death. In his dialogue *Phaedo,* for example, ancient Greek philosopher Plato famously defined philosophy itself as *meletē thanatou*, the practice or preparation for death, and the 20th-century philosopher and writer Albert Camus insists, equally famously in his *Myth of Sisyphus,* that the only serious philosophical question is the question of suicide. However, it was not until recently that professional philosophers began to address questions about death at any length. This entry treats only a few of the conceptual, metaphysical, and ethical issues concerning the philosophy of death and dying. These issues include philosophical problems regarding the definition of death, immortality, existential perspectives, and moral and ethical questions concerning death and the dead.

The Definition of Death

The most fundamental philosophical problem regarding death is how to define it. A common starting place is to warn against the ambiguity of the term: Death may refer either to the *process* of dying, the *event* of death, or the *state* of being dead. Rigorous philosophical work distinguishes in just what sense or senses the term is used. When philosophers speak of death, they are primarily denoting the event, the state, or both.

The next task is to provide the definition. Here philosophers distinguish a *definition* proper from a *criterion*. A definition tells us what death essentially is, what its necessary and sufficient conditions are; a criterion specifies a procedure for determining whether (and sometimes when) death, as defined, has occurred. A common biological definition of death for mammals identifies it with irreversible cessation of vital organismic functions. Philosophers wrestle with precisely which functions are meant. Traditionally, the permanent loss of respiratory and circulatory function was thought to equal death; today most philosophers prefer to define death as the permanent cessation of brain functioning, though they debate whether this means the whole brain, including the brain stem, or rather just the "higher brain," the parts that govern consciousness and thinking, particularly the cerebrum and cerebellum.

Conceptual problems related to biological death mainly concern whether the specified physiological functions are both necessary and sufficient for death. The irreversible cessation of the breathing and respiratory functions is arguably not *sufficient* for death, as some brain function may persist even after breathing and respiration have ceased, nor may it be *necessary* for death, as someone who lacks any and all brain activity but whose circulation and breathing are artificially sustained may plausibly be regarded as nevertheless dead. Similar problems relate to brain accounts. If cessation of higher brain activity is *sufficient* for death, this implies that someone in a coma or persistent vegetative state is dead, even when all other vital signs are normal, a conclusion most are unwilling to accept. Similarly, whole-brain death is apparently not *necessary* for death because trace amounts of brain activity does not qualify one as alive when all other vital processes come to an end. A related question concerns whether death is a threshold concept, that is, whether one may be *more* or *less* dead to the extent that the essential vital processes have deteriorated irreversibly or permanently ceased.

Further conceptual problems arise when the issue shifts from the nature of death in general to that of *human* death in particular. There is a general consensus about how human death can be biologically defined: A human is dead if and only if *either* all breathing and circulation have permanently ceased *or* all brain activity has permanently ceased. But can human death be defined in a purely biological way? Many philosophers follow our common intuitions that because human beings differ from most animals in their possession of rational agency, human death must be defined as involving a permanent loss of *self* or *personhood*. The philosophy of death thus connects with philosophy of personal identity.

Existential Perspectives

Much of the current philosophical interest in death can be traced back to the French and German existentialist philosophers of the pre– and post–World War years. The existentialists eschewed the abstract theorizing of the tradition and insisted on the analysis of human existence. One of their major concerns was with people's awareness of their own mortality and its role in their deciding how to live their lives. The foundational work is the German philosopher Martin Heidegger's *Being and Time* (1927). The work begins with what its author calls an "existential analysis" of *Dasein*—Heidegger's term for human worldly existence. One of the essential characteristics of *Dasein*, according to Heidegger, is "being-toward-death." Every person is aware of himself or herself as mortal, of his or her life as temporally limited. Heidegger was interested in the potential of this often tacit awareness to spur an individually authentic existence. For him, human existence is largely inauthentic, defined in large part by an immersion in the crowd, which Heidegger famously refers to as *das Man* ("the They," "the One"). We normally make our life choices in accordance with the expectations of others. If we think of death at all in this condition, we think of it as something far away, as an accident of sorts that befalls people in general, rather than as something specific and fraught with implications for the choices we make about how and what to be. But the anxious realization that our death is *always* a possibility and not just a remote one, that death as the "impossibility of all possibilities" is always final, and that our death is always "our own" and no one else's can keep us out of step with the crowd. With the lively awareness of death as our "own most possibility," one that "cannot be outstripped," our realization of the need to live and define ourselves on our own terms takes on greater urgency.

Heidegger's analysis of mortality was immediately influential on a generation of existentialist thinkers, both religious and secular. The existentialists by and large accepted Heidegger's view of death as the ultimate limit of existence—Jean-Paul Sartre, in his well-known *Being and Nothingness*, is a lucid example—and they agreed on how our awareness of our own being-toward-death may jolt us into a more authentic way of life, but they criticized Heidegger's account as overly individualistic.

More sympathetic with ethics than was Heidegger, later existentialists insisted on the importance of our relations with others in our decisions concerning how best to make use of our limited lifetimes. Simone de Beauvoir, in her account of her time with her dying mother in *A Very Easy Death,* as well as in her essay "Old Age," argues convincingly that one cannot even fully understand the reality and significance of mortality entirely from a first-person perspective. To appreciate fully your own finitude, you must see yourself from others' perspectives, including those who are close to you; you recognize *their* realization that *you* will not live indefinitely.

Immanuel Levinas, whose early work is also associated with existentialism, also brings mortality and relations with others together. According to Levinas, the primary significance of one's being conscious of one's finitude is ethical: A person experiences death as a limit on his or her mastery over existence, as constraining his or her freedom. The experience is preparatory for morality, because such self-limitation is precisely what is required for genuinely ethical relations with others.

Questions About Immortality

Matters concerning the definition of death have obvious implications for the question of whether people can somehow survive their deaths. If human death is defined as entailing the permanent loss of self or personhood, then personal immorality is seemingly precluded. In debating this issue, philosophers usually begin by distinguishing the mere survival of death from immorality proper. It is conceivable that something about us may survive the destruction of our bodies, but if what survives is merely, say, a shadow of our former selves or a ghostly image of our premortem bodies, this would not amount to personal immorality, strictly speaking. The latter involves forever retaining our full identities after death, and for that most philosophers agree that something like a soul is required.

The founding document of the pro-immortal soul position remains Plato's *Phaedo*. The dialogue documents the last conversation of Socrates with his disciples only hours before his execution. Not surprisingly, the topic turns to death. Socrates breaks with then-prevalent Greek accounts of the soul as a shadowy, quasi-material substance that resembles the living person in favor of the dualistic view of the soul as a simple immaterial substance that is not susceptible to dissolution. He argues that if one takes proper care of the soul during one's lifetime, by pursuing a philosophical life, thus pulling the soul away from the body and its attachments to physical satisfactions, then the soul will be freed from its bodily imprisonment at death—this is why philosophy is the "preparation" for death. For Plato, death is a blessing for those who live contemplative lives; nonphilosophers can only expect continual reincarnation, one bodily imprisonment after another.

Some contemporary philosophers also argue for human immortality. The majority who take up this issue believe that science has successfully demonstrated the dependence of the person on the brain, and they argue that the destruction of the latter entails the annihilation of the former. Consequently, most philosophers ask not about the reality of immorality but rather about the necessity of our hopes for immortality, the coherence of these hopes, and even the desirability of everlasting life. Even if humans necessarily long for immortality, could they find meaningful and fulfilling a life in which any desirable project can be put off indefinitely? Would not an endless existence be tedious? Might not death be a condition of the possibility of a meaningful life? These are major points of contention in the field.

The Harm of Death

It is widely thought that death, at least premature death, harms or is a misfortune for the one who dies. This position was challenged by the Hellenistic philosopher Epicurus. His enduring argument has two parts. First, Epicurus was a hedonist in the sense that he thought all good consists in pleasurable

sensations, all bad in painful sensations. Second, in opposition to Plato, who in the *Phaedo* advanced several arguments for the personal survival of death and the immortality of the soul, Epicurus insisted that the event of death effects the total annihilation of the self. Since at death one no longer exists, there is no subject to experience pleasure or pain, and hence death is neither a good nor an evil for the deceased. In stark contrast to Plato, Epicurus contended that death is nothing to us, no more to be feared than hoped for. The ancient Roman philosopher Lucretius, a follower of Epicurus, supplemented the latter's argument with his own so-called symmetry argument. Because we rationally do not regard our lack of existence before our births as bad, Lucretius reasons, it is irrational to look upon the state of death as bad, since the two nonexistences are indistinguishable. The merits of these and related arguments are hotly debated by philosophers today.

Critical responses to Epicurean arguments are manifold. Lurtetius is said to reason from a false premise that one's preexistence and postexistence are qualitatively the same. What differentiates these states most importantly is that the former is followed by existence and the latter follows existence, and this difference can justify different attitudes toward each. While it may make no sense to regret one's preexistence—because no one could really be born much earlier than he or she is without ceasing to be the same person and because preexistence doesn't indicate the end of all one's meaningful projects or living relations—it is natural to regret having to die precisely because we know that it brings these projects and relations to an end. Criticism of Epicurus's argument generally focuses on the hedonistic thesis that identifies good with pleasure and bad with pain. Most philosophers today reject not just hedonism but all doctrines that identify good or bad solely with subjective states. Instead, they endorse the view that certain things can benefit or harm someone even if he or she is unaware of them. That there is no self at or after death to experience anything, they argue, does not preclude our saying that the person has incurred a misfortune or harm.

On the assumption that a deceased person can be harmed by death or by posthumous events, philosophers are obliged to clarify just how this is possible. Some make use of "possible worlds" theory. Imagine two worlds: one, which happens to be the actual world, in which a particular person dies a premature death, and another nonactual but logically possible world, in which the same person lives well past life expectancy. With all other things being equal, are we not justified in judging the person worse off in the first world than in the second, and, if so, is it not true that that person is harmed by early death? Whereas some philosophers find such thought experiments fruitful, others reject the idea that such counterfactual reasoning can establish anything definitive about the harmfulness of death.

Another major issue is *when* a deceased person may incur harm. Putting aside the question of whether the event of death may harm a person, questions persist about posthumous events. To take a common example: Suppose that someone who strongly values a good reputation dies; afterward, that person's reputation is widely besmirched by malicious slander. It is tempting for many to say that the dead person is certainly harmed by the slander; the question is how this can be true given that the person no longer exists. One line of thought says that the harm is *concurrent* with the person's death: Even though the slander has yet to take place, the harm it inflicts *must* be concurrent with death if it is assumed that a nonexistent subject can be directly harmed. Another school of thought argues that the harm of posthumous events is *antemortem,* that it happens *before* the person dies. The idea is that because the person valued a good reputation while alive, it is the person's *living* self that actually incurs the harm of the posthumous slander. Still other possibilities abound: Perhaps the harm does occur but at no definite time. Such questions comprise what some call "the timing puzzle."

Moral and Ethical Matters

Philosophers are taking a growing interest in how questions about death relate to moral theory and applied ethics. A major controversy is what kind of moral consideration the deceased should be accorded. The question riddles diverse stances in moral theory. Utilitarianism, for instance, defines a morally right action as one that maximizes some good, say happiness or the satisfaction of interests. But whose happiness, or whose satisfaction,

is to be accounted for in making calculations? According to some, only currently living beings (humans certainly, perhaps other animals too) should be considered. Other philosophers wonder about people of future generations. The question carries over to the dead. Theorists contest whether the interests of the deceased—the question being whether the dead may have interests—get consideration in moral decision making. Similar questions apply to Kantian or respect-for-persons ethics, the major alternative to utilitarianism in moral theory. Central to this view is that any actions that fail to treat people as "ends-in-themselves" is wrong. To treat people as ends in themselves is to regard their moral agency as valuable and to refrain from treating them as mere instruments to be used for the purposes of others. A problem Kantians must address is whether the dead as well as living should be regarded as ends in themselves. The reality of death thus intersects with the fundamental issue of who qualifies as a member of the moral community.

Questions about the moral status of the dead pervade applied ethics as well. Ethicists debate, for instance, what constitutes respectful treatment of the dead. As with many areas of applied ethics, common practices in the sciences are called into question. Controversy surrounds the treatment of cadavers for medical research, the upsetting of burial remains for archaeological investigation, how to use or treat scientific or artistic work left by the deceased, and so forth. Such straightforwardly moral issues, together with the aforementioned work regarding the harmfulness of death, probably comprise most of the current philosophical literature on the topic.

Randy Cagle

See also Brain Death; Death Anxiety; Immortality; Life Expectancy; Soul

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Death, Psychological Perspectives

A variety of aspects of death impact daily life, influencing attitudes and feelings about death. Death deals with the meanings humans attach to it, their responses and reactions to loss, and the developmental aspects of death, that is, how death's salience varies across the life span. Indeed, humans are unique in that we anticipate death (our own as well as deaths of others), reflect upon how to live life, and consider how and when death will descend upon us. Embedded in a culture that is sometimes described as death denying, it is important to acknowledge feelings about death and dying, as these are influenced by both personal experiences and cultural aspects. Such experiences also impact those aspects of death to which humans are exposed.

The Meaning of Death

Both age-related and individual differences in awareness of death contribute to the meaning assigned to it. Variations in such meanings either enhance or suppress attention to death-related experiences, which may vary with age or with historical events that shape the nature of death itself and one's response to it.

For most individuals, death is the ultimate loss in our lives, whereas for others, death may mean punishment for one's sins. Death may also be seen as a transition between one form of existence and another. Indeed, there are as many idiosyncratic

meanings persons assign to death as there are people, though the tendency to personalize death is commonplace among children and older adults.

Responses to Death

Feelings about death, influenced by the meaning attributed to it, often determine the quality of life one has to live. In this context, one response to death or dying is termed *overcoming*. Overcomers see death as the enemy, as external in nature, or as a personal failure. Others show a participatory response to death, wherein death is internal, an opportunity to be reunited with a loved one, and is a natural consequence of having lived. Indeed, as people age and/or approach death, they become more participatory.

What life and death mean likely influences how persons respond to death. Although fear and anxiety are not the only responses to death, these have received considerable attention over the past decades. Whereas some might fear the losses accompanying death, others may fear the loss of control over their everyday lives. Recognizing such fears can enhance the quality of one's life, while ignoring them may lead to self-deception. In this respect, there are many manifestations of the need to deny, manipulate, distort, or camouflage death so that it is a less difficult threat with which to cope.

Many attempts to cope with death reflect the perception of death as something to be avoided, and recent historical shifts in our response to another's death and dying, the removal of death from our presence via a brief funeral, and the medicalization of death are both individual and cultural manifestations of this death denial. Indeed, assertions that an awareness of one's mortality initiates a midlife crisis, that persons first respond to the news of their own imminent death by denying its reality, as well as debates about the validity of near-death experiences have all normalized the construct of death denial among social scientists.

When considering fear and anxiety as responses to death, it is instructive to recognize that these constructs exist along a continuum. For this reason, it may be difficult to distinguish between normal and neurotic components of death anxiety, as they may be intermingled in most people. This continuum suggests that denying death is normal and consistent with the personal-cultural style described earlier as overcoming. Indeed, denial should be considered as adaptive to the extent that it is not overused, though there are certainly persons for whom its overuse is indeed pathological.

Grief and Bereavement: Individual Differences in Responses to Loss

The experience of bereavement is the reaction to the loss of a close relationship and is co-defined by grief (that is, the individual's feelings regarding the loss and mourning) and the culturally patterned expressions and rituals that accompany loss and allow others to recognize that a person is bereaved (e.g., wearing black). Normal grief reactions are somatic (disturbed sleep, loss of energy, diminished appetite, headaches, difficulty in breathing), behavioral (crying, withdrawal, overdependence, inability to perform daily tasks, disinterest in work, restlessness, expression of anger), and intrapsychic or emotional (shock, emotional numbness, sadness, fear, guilt, anger, loneliness, worry, anxiety, hopelessness).

Grief is best understood to include two components: an emotional reaction to losing a close attachment relationship and a need to cope with secondary stressors resulting from the death (disrupted finances, threats to family security, having to assume new family responsibilities). Although there are universal aspects of grief, the process of grief is an individual journey. For most persons, the work of grieving is a struggle between realization of loss and retention of the lost person, and it is clear that the supportive presence of others with whom the individual can share his or her grief is a key element in healthy grieving. Ultimately, the bereaved person is able to forge new relationships and take on a new postbereavement identity, wherein a new relationship to the deceased individual is formed.

Taking a goal-oriented approach, there are four basic tasks of grief: (1) acceptance of the reality of the loss, (2) working through the pain of grief, (3) adaptation to life without the deceased, and (4) engagement in new relationships. Recently however, this view of grieving has been challenged by one emphasizing the dual process model of coping with loss defined by responses to the loss of the relationship to the deceased individual (a loss orientation), where active grief work (e.g., a preoccupation with the death, heightened emotional

responses to the individual's absence) is emphasized, and responses to changes in one's lifestyle and relationships with others (a restoration orientation), which often coexist with a loss orientation. Over time, individuals shift from one orientation to another, depending on life circumstances, needs for social support, health, or requirements to learn new life or work skills. This dual process model asserts that there are indeed times when denial or avoidance of active grief work would be advantageous, and thus stresses the adaptability and flexibility of individuals' response to loss over time.

The symptomatology of grief can be complex and can involve a mix of potentially disruptive emotions (e.g., depression, anxiety, loneliness, and guilt), physiologic-somatic symptoms, disrupted everyday functions (e.g., disturbances in sleep and cognition, changes in self-regulation, immune functioning), diminished capacity to cope, and increased vulnerability to illness. In this respect, the distinction between normal and pathological grieving hinges upon the extent to which the loss of a valued relationship interferes with the older person's everyday functioning, work performance, relationships, emotional and cognitive status, and health. While these contradictory emotions complicate the distinction between normal and pathological grief, accepting such emotions seems to positively predict bereavement outcome. While social isolation undermines this distinction as well, and for most bereaved individuals, feelings of isolation and separateness from others are major obstacles to asking for and receiving help.

Maladaptive or pathological grief frequently involves a long-term change in the individual's typical behaviors, for example, in the form of chronic depression, extended denial of the death, self-abusive or self-destructive behavior, or isolation from others. In contrast, normal adaptive grief may or may not last for an extended time period (e.g., 2–3 years), depending upon a number of factors (personality, health, relationship with the deceased person, support from others). Although for many persons, grief follows a predictable course, adjustment to the loss of a loved one is nevertheless a complex process that changes (a) one's health and relationships with friends, family, and coworkers; (b) views about oneself; and (c) one's roles as community member and coworker.

Grief and Bereavement: Contextual Influences

As grieving is best conceived in terms of an individual in the context of relationships with others' experience, persons' responses to loss are influenced by a number of factors that affect the intensity and course of grief and mourning. These include relationship to the deceased, the nature of this relationship, the bereaved individual's history of loss, the availability of social support, the nature of death, one's cultural background, and personality of the bereaved person. These influences dictate the nature of grief (whether it is complicated or pathological), its intensity, and its duration.

These contextual parameters influence the experience of bereavement and interact with developmental differences in responses to death. For example, in later life, losing a spouse of many years can be especially disorganizing for older widow(er)s and may signal increasing dependency on others. For older adults, it is the loss of an adult child or a grandchild that is the most unforeseen, and indeed, older persons' own needs are often sacrificed in the service of meeting others' needs when such deaths occur, where older persons' grief is disenfranchised; the needs of younger persons may be put ahead of one's own needs to talk about the loss, leading to emotional isolation from others, who do not recognize the importance of being able to talk about one's feelings in the face of loss. For younger adults, the death of a spouse or child is likewise a nonnormative occurrence, that is, it is "off time," as is the death of a parent for a child. In such cases, the grief attached to death would be considered acute in nature and therefore more psychologically disruptive. Consequently, greater attention should be paid to providing social support as well as reinforcing a sense of personal safety and well-being in the face of loss for such persons. Similarly, if a son or a daughter had grandchildren, grandparents may have to raise these children and yet be faced with caring for themselves, wherein the grandparent's fears for the grandchild's welfare may emerge in view of the former's perceived imminent death.

Sudden or unexpected death via accidents, murder, suicide, or heart attack/stroke elicits more intense acute grief than a death for which the

family has had time to prepare emotionally; in the latter case, persons are said to experience anticipatory grief. When the trajectory of the illness is more predictable and elongated, grievers, although saddened at the death, at least have the opportunity to emotionally process the loss, as might be true for death by cancer, Alzheimer's disease, or AIDS.

Regardless of the cause of death, the process of dying, popularized by Kübler-Ross as a series of stages dying patients go through, disrupts relationships with parents, children, and spouses; interferes with one's future goals and plans; and often undermines one's sense of attractiveness and sexuality. Understandably, a terminal illness or a sudden death leaves family and friends feeling frustrated, angry, and lonely. Because death in childhood or young adulthood is nonnormative, individuals feel angry and cheated that the personal or career goals they have set for themselves are never going to be reached. If middle-aged or elderly persons have experienced the death of adult children or grandchildren, they must experience the sadness of not seeing them grow up, marry, and raise their own children.

Developmental Aspects of Death: Children and Adolescents

Children tend to grieve episodically, relying on repression and denial as coping mechanisms to keep their grief under cover, perhaps creating the illusion that the child is over the death of the parent. Indeed, it is not unusual for a very young child to have grief work to do for some time. Many surviving children who are considered "bad" may be in dire need of professional intervention. As grief is in part influenced by understanding of death, it is likely that children's awareness of death is largely a function of the interaction between developmental changes in the ability to think abstractly and the accumulation of death-related experiences. Indeed, there do appear to be at least semiregular developmental changes in the understanding of death, wherein children progress through three phases: (1) believing that death is not real, that the dead have lifelike properties (e.g., death is like sleep); (2) personalizing and/or externalizing death; and (3) understanding death as being internalized, universal, unavoidable, and irreversible. Despite these shifts, it is important to note that there are individual differences among children of a given age in their understanding and awareness of death. Death-related experiences help to account for such differences, as do individual differences in personality and the extent to which the family communicates openly about death. The deaths of grandparents, friends, heroes (sports figures, rock stars), and parents are powerful influences on children's awareness of death, as are culturally relevant experiences, for example, the Columbine High School shootings in 1999.

While it is clear that the death of a parent has a profound impact on children and adolescents, children often reexperience grief related to parental death as they mature. For example, for young children, a parent's death may signal the loss of safety, whereas for these same individuals as adolescents, struggles with one's identity may be influenced by the parent's death. To this extent, attempts by the child, in concert with those of the surviving parent, to "reconstruct" the deceased parent seem to be helpful. When a parent dies, adolescents often experience impaired school performance and disrupted, conflictual relationships with peers, and for some children and adolescents, the impact of such deaths can be far-reaching. Complicating matters is the fact that death has specific connotations for children depending on who dies (e.g., a pet, a parent, a friend, a grandparent). Likewise, some children may be unable or unwilling to let anyone know how they may be thinking about their own death or the deaths of others.

Adolescents' awareness of death is tied to the deaths of friends (e.g. suicides, accidents), parents, or grandparents and is intimately bound to their efforts to define themselves as unique individuals and to establish intimate relationships with others. Communication with other family members is disrupted. This is also the case when a sibling dies, though its impact varies by age. In each case, providing support and sameness in the face of loss is critical.

Developmental Aspects of Death: Adulthood and Later Life

In adulthood, responses to death are quite variable and yet have a quality of sameness about them. Indeed, in comparing younger and older

adults, older adults often experience a mix of physical, emotional, cognitive, and social consequences similar to those found among younger bereaved persons. Acknowledging individual variations, the pattern reflects an elevation of symptoms in the first months postloss and then gradually diminishing symptoms as the individual finds some success in adaptation.

For young adults, death comes, for the most part, unexpectedly. Rather than dying because of disease, when young adults die, it is often by accident or through violence. In most cases, however, death is due to homicides, auto or motorcycle accidents, or, in some cases, because of war. Understandably, though rare in young adulthood, a terminal illness or a sudden death leaves family and friends feeling frustrated, angry, and lonely. Because death in young adulthood is nonnormative, individuals feel angry and cheated that the personal or career goals they have set for themselves or others are never going to be reached. If they or their children die, there is the sadness of not seeing their children grow up, marry, and raise their own children.

Young adults who lose children through death, particularly if those children die at a relatively young age, grieve for long periods of time and experience great personal distress for as long as 5 years after the loss. Funerals may be avoided. Parents may assume that they are responsible, that they should have done something to prevent their child's death, and often they feel alone, angry, and resentful toward others and may be disappointed in one another. Some families seek professional help to assist them in working through their grief. For others, community support is very important. One such self-help group is The Compassionate Friends. In this context, parents whose children die grieve along two dynamic dimensions: personal functioning and relationship to the dead child. While both age of the child and a parent's age interact to dictate the impact of child loss, the death of a child requires a "lifelong accommodation" to the loss of a child.

For adults who are in their 40s and 50s, the possibility of their own death becomes real. Cancer, heart disease, stroke, and heart attacks are the major killers of middle-aged adults. For men, lung, colorectal, and prostate cancer become major concerns, whereas for women, lung, breast, and colorectal cancer are the most common. In this context, for individuals facing a terminal illness, reevaluating life and its meaning are likely consequences. The quality of one's relationships, as well as one's achievements and goals are assessed with a finality that was never present before. Plans for the future must be made. If the cancer is incurable, then the rights and obligations of the person as a dying individual come into play.

Death also affects middle-aged individuals through the loss of one or both parents. Because such deaths are often anticipated, adult children's grief may be disenfranchised. The circumstances (e.g., quality of life, living arrangement) often mediate the impact of a parent's death in adulthood. The fact that a parent is still alive serves as a psychological buffer against death. Stripped of this "protection," one must acknowledge that he or she is now the senior member of the family and that death is a certainty. Although children certainly mourn and grieve over the loss of their fathers, mothers may represent the last evidence of one's family of origin, as women typically outlive men. A parent's death symbolizes many things: one's own mortality, independence from authority, attachment, and love. A parent's death may coincide with personal, marital, or work crises; the loss of a parent may intensify a couple's marital difficulties.

Late adulthood is often equated with many losses, such as good health, relationships with others, and status in the community as independent and productive persons. Perhaps the most important losses thought to accompany getting older are those of one's spouse and, ultimately, the loss of one's own life. Older people are likely to have had more death experiences (parents, siblings, friends) than are younger people. This has several consequences: (a) The future seems more finite rather than being infinite, (b) older people may see themselves as less worthy because their future is more limited, (c) desirable roles are closed off to them, and (d) not knowing what to do with one's "bonus time" on earth, one may think that he or she has already "used up" what years were available. Lastly, as more friends and relatives die, older persons become more attuned to sadness and loneliness and to signals from their bodies that say that death is near. Death is further normalized in later life via its association with the age of integrity.

The principle of compensation may preserve a sense of continuity and fairness about life and death for some older persons, suggesting that older or terminally ill persons are compensated for the losses of health and ultimately life itself by the promise of eternity. This reinforces the practice of regressive intervention that there is nothing more that could have been done for the old person who is near death. Thus, we may expect the death of someone who is older, whereas we are caught off guard when someone young dies. Similarly, we may believe that younger persons have a more difficult time adjusting to the loss of a spouse than do older individuals.

It is indeed prudent to remind ourselves of the idiosyncratic nature of what death means to children and adults, as well as the variability across similar and different developmental transitions in response to such meanings. Each death is at once an individual, a familial, a community, and a cultural experience. Thus, death understanding is best thought of as something individuals construct and reconstruct, based on developmental life experiences and cultural shifts in the causes of and beliefs about death.

Bert Hayslip Jr., Melissa L. Ward, and Robert O. Hansson

See also Adolescence and Death; Adulthood and Death; Death Anxiety; Kübler-Ross's Stages of Dying; Middle Age and Death; Quality of Life

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Death, Sociological Perspectives

Most sciences of the human condition—including history, social psychology, philosophy, anthropology, religion, political science, and sociology—address the problem of mortality. Many find it difficult to demarcate a sociology of death because the discipline's subject matter often overlaps that of others, as when studying the economic underpinnings of religious violence or the philosophical justifications of political pogroms. Further, often the practitioners do not perceive or frame their work explicitly in terms of a death and dying specialty. For instance, sociologists studying the epidemiology of cancer death rates of those living in proximity to military bases, sewage treatment centers, or coal energy plants may not identify their research in terms of a sociology of death and dying but rather classify their work as case studies in eco-racism. Finally, given the general absence of theoretically driven substantive research, some argue that there really isn't a sociology of death—or, if there is, it remains in some nascent state—and the field is defined more in terms of its subject matter rather than any overarching theoretical enterprise. Nevertheless, sociology provides distinctive perspectives to both broad- and small-scale death-related phenomena.

The Macroscopic Perspectives of Sociology

Among other things, the "sociological imagination" entails taking broad social perspectives in addition to those of individuals. From this vantage point, for instance, death can be seen as being socially functional as well as dysfunctional. In the *Structures of Scientific Revolutions,* Thomas Kuhn argues that major paradigm shifts in the natural sciences occur not because proponents of new ones convince or persuade the supporters of old ones, but rather because supporters of the old paradigms die off. Analogously, consider white Americans' responses to the question "Do you think there should be laws against marriages between blacks and whites?" In 1972, 39% of whites favored such laws; 30 years later, only 10% did. Of those born before 1900, 65% thought there should be laws prohibiting miscegenation

compared to only 7% of those born 1970 onward. Much of this change in attitude owes not to civil rights or affirmative action legislation but rather to the deaths of those holding antiquated racist views. Here detailed are several broad sociological perspectives of death's power to destroy, enhance, or otherwise alter the broad social fabric.

Death as a Measure of Life

Perhaps one of the discipline's earliest traditions has been to take death as a barometer by which to understand and measure the adequacy of social life. In *Suicide*, Émile Durkheim, one of the field's founding fathers, conceptualized acts of self-destruction resulting from either excessive or inadequate levels of social integration and regulation, initiating the enterprise of determining what social factors correlate with who dies, how, when, where, and why. For instance, sociologists studying inequality systems compare such measures as rates of infant mortality, life expectancies, and homicide between different social groups and how they change longitudinally. Progress can be inferred from actuarial change: Whereas in 1900, for instance, white males had a 43% greater life expectancy at birth than black males, by 2004 this advantage had declined to 8%. Societal regressions are also made evident: Russian life expectancies at birth in 2004 were less than they were 40 years earlier during the Khrushchev era. Cases of ethnic cleansings, suicide bombings, and assassinations are indicators of social disintegration.

The stratifications of life are symbolically dramatized by the stratifications of the dead, such as the racial, ethnic, religious, and class segregations between and within a community's cemeteries. In the Texas Hill Country can be found a "Republicans Only" cemetery. Obituaries, particularly those in the national media, are reaffirmations of the social registry of the élite.

Social Impacts of Changing Death Demographics

In 1900 an estimated 39% of newborn males and 43% of females could expect to survive until 65, compared to 78% of males and 86% of females born in 2002. A white American female at birth now has a greater chance of surviving to 65 than did her counterpart in 1870 have of seeing her first birthday. Such changes in the demography of death have had a profound impact on how lives are lived and deaths experienced. Also impacted are broad social dynamics. For instance, the two changes underlying the longevity revolution—specifically, the dramatic decline in infant and childhood mortality and life expectancy increases—dramatically alter societies' age compositions and therefore the various institutions (i.e., schools and the military) addressing the needs of (or reliance upon) different age groups. Modern societies now face such questions as how the aging of their populations affects the rate of social change, social expenditures for education as opposed to late-life medical care, military adventurism, or the pace of technological innovation. With old age replacing childhood as the most death-prone stage of the life cycle, cultural gerontophobia (fear of aging) has become interwoven with cultural thanatophobia (fear of dying).

Types of Societies and Differences in Their Views of Death and Death Fears

Sociologists overlap with their anthropology colleagues in conceptualizing how the entirety of a culture's death beliefs, symbolizations, and mortuary practices fit together. This sum of parts, called a culture's death system or death ethos, determines such widely ranging phenomena as a society's militancy, homicide rate, and use of capital punishment; its people's willingness to take risks or undergo abortions; their fears of or hopes for reincarnation and resurrection; their willingness to receive organ transplants or to purchase life insurance; and their preference for burial or cremation. So great is the power of this death system—this construction of meaning erected against the terror of death—that various social agencies seek to harness its energy as a method of social control. Specifically, this "harnessing" occurs through giving meaning to death's occurrence, by reminding individuals of their mortality, by assisting them in outliving their contemporaries, and by providing opportunities for its transcendence.

Death's Power to Enhance Social Solidarities

According to terror theory, based on the works of Ernest Becker, when awareness of death is

increased, in-group solidarity intensifies, outgroups become more despised, and people react more harshly toward moral transgressors and more favorably toward those who uphold their values. Death is a catalyst that, when put into contact with any cultural order, precipitates out the central beliefs and values of a people.

As evidenced by bullfights, gladiator contests, public executions, and both regime and antiregime funerals, death has the power to control attention and to induce cohesiveness among observers. Of all phenomena, death demands attention most, as its presence normally rips individuals out of their everyday automatic routines and forces them to think the unthinkable. Social institutions attempt to capture this power through ritual, which explains the near-universality of funerals and ritual sacrifices.

With increasing modernity and with death largely removed from everyday life, death's powers are often amplified in *Gesellschaft* societies. For instance, following the terrorist attacks of September 11, 2001, the sense of patriotism and unity in the United States had rarely been greater since World War II (with the possible exception of the funeral of slain President John F. Kennedy).

Mechanisms by Which Societies Limit the Disruptions Caused by Their Members' Deaths

Through funerary ritual, rules of inheritance, rules of succession, disengaging or depersonalizing those most likely to die, and simply hiding death (as in the Defense Department's banning of flag-draped coffins of casualties of the Iraq and Afghanistan wars), societies dampen the potential of their members' deaths to demoralize, instill fear, or otherwise disrupt social life.

The smaller the group or the greater the number of deaths, the more devastating these disruptive impacts can be. In *Gemeinschaft* societies, such as the small towns and rural cultures of the 19th century where people knew one another intimately, individuals often had unique, important, and irreplaceable functions. Their deaths could not be ignored; they had to be marked by community-wide outpourings of grief for genuine social losses and for collective reaffirmations of shared values so that the stricken group could reestablish and reintegrate itself.

As societies grow and evolve into increasingly differentiated and specialized complex structures, individuals become but interchangeable parts with such death-compensating mechanisms as rules for succession and mandatory retirement becoming institutionalized. It could be argued that the central accomplishment of modern societies has been to largely control untimely death—and to remove from everyday life as much death as possible.

The disruptive potential of death is, in part, a function of who dies, such as a political leader or religious visionary, and how the death itself affects the moral order. This moral order includes such experiences as sense of fairness, social pollution, and harm to social systems of trust and cooperation. Dead infants found in garbage dumpsters may produce large community funerals, whereas a deceased homeless man may become as invisible in death as he was in life. Disruptiveness is also a function of how death occurred and how able social organizations are to quickly respond. Floods, earthquakes, hurricanes, aircraft crashes, and other disasters causing considerable loss of life require extensive coordination of national, state, and local organizations and volunteers. Sociologists have long studied such situations, detailing how divisions of labor emerge to repair the rent in the social fabric. Also studied are the differences in social response to mass death—and the moral issues revealed. Why, for instance, were families of those killed in the terrorist attacks on the World Trade Center and Pentagon compensated $1.6 million on average whereas families of those killed in the terrorist bombing of the Alfred P. Murrah Federal Building in Oklahoma City received less than one-tenth that amount?

Death as Mechanism of Social Control

Whereas sociologists from the structural functionalist perspective tend to focus on the power of death to enhance social solidarities, those examining death from a conflict perspective are more likely to focus on the ways in which death and death fears have been used to oppress or otherwise control the thoughts and actions of individuals in order to consolidate the power of the ruling elite. Death fears and actual killings have long been mechanisms by which the ruling elite consolidated power. Mao Zedong (Mao Tse-tung) and Joseph Stalin allowed

tens of millions of their own people to starve to death in order to implement social change. The "honor killings" of female family members in some Islamic societies and the lynchings of black males in the American South were tactics to keep women and blacks in their place during times when both groups began questioning their unequal statuses. Another strategy to quell internal dissent has been to direct public focus on some life-threatening enemy, which invariably leads to the coalescing of support around the leader of one's group.

The historical ascendancy of the state as the most powerful social agency against death (and states' attempts to monopolize violence) has a host of implications. Political structures of power can be ultimately seen as collective efforts to control death and death fears, whether the threat be viruses, terrorists, pollution, or stray meteors. With modernization, most premature death occurs because of man-made (hence theoretically avoidable) causes. Concurrently, and not unrelatedly, modern political regimes became the social institutions providing the cultural rituals for death control and death transcendence. Eisenhower's military-industrial complex has evolved into the medical-military-industrial complex that has evolved as the skeletal structure of the social organism. Death beliefs and fears have become increasingly politicized, replacing their traditional religious counterparts as mechanisms of social control.

Mapping Institutional Influences on Cultural Death Systems

Social power concentrates in that institution best able to harness death's power. Such "harnessing" occurs through giving meaning to death's occurrence, by reminding individuals of their mortality, by assisting them in outliving their contemporaries, and by providing opportunities for its transcendence. Not surprisingly, battles for control over the rituals and ideologies of cultural death systems have arisen. For instance, conflict has arisen between religious authorities and funeral directors over the final rite of passage, including whether the ceremony's location is to be within the church or funeral home chapel, whether the casket is open or closed, and whether the clergy members or funeral directors are more qualified to act as grief counselors.

Among the greatest social controls ever devised by humanity to control its members' actions are the envisionments of various fates in the afterlife. Differing dramatically in terms of their desirability, religions harnessed their associated fears and hopes with elaborate belief systems that connected the quality of postdeath existence with the moral worthiness of the lives lived. Sociologists of religion have long studied the social distribution of beliefs in an afterlife, ascertaining why the increase in Americans' faith in the existence of life after death (which increases with education among Catholics and most Protestant denominations) and how that affects their social behaviors.

With secularization and the medicalization of death, cultural death fears are shifting from fears over postmortem fate to fears of the dying process. As a result, rituals for controlling death fears now change from prayers and moral lifestyles to obsessions over healthy lifestyles, featuring observances of diet and exercise regimens. This has led to the increasing economic power of the medical establishment and the political (and social) status of the medical elite.

According to the World Health Organization report of 2008, tobacco use killed 100 million people worldwide in the 20th century and could kill 1 billion people in the 21st century unless governments act immediately to dramatically reduce it. How did such usage rates come to be? The American government has long subsidized tobacco farmers, whose crops are key American exports to the global economy. During World War II, soldiers were issued cigarettes as part of their rations; until the 1990s, military commissaries sold deeply discounted cartons. Hollywood long glamorized and sexualized the practice. Social scientists, hired by tobacco companies, conducted focus groups with children to study ways in which children could be made into smokers. Why is it the responsibility of governments to ameliorate the problem?

With death largely removed from everyday life, thanatological lessons increasingly derive from the mass media, which exploit death's taboo status within death-denying cultures. Television's excessive use of death in news stories and program plots enhances viewership but possibly leads to desensitization and copycat behaviors. "Pornographic death," in which attractive female victims of homicide, suicide, and accidents are displayed, has also

been employed by advertisers to sell clothing, shoes, and perfumes. And to bring attention to their music, rock groups bear names such as Megadeath, Dead Kennedys, Grateful Dead, and Cannibal Corpse.

Memorialization, Collective Immortality, and Symbolic Immortality

Rituals for collectively remembering the dead also fall within the sociology of death and dying purview, whereby societies confer symbolic immortality to their elect in order to reaffirm core values and to provide the sacred sense of connection with past, present, and future generations. Sports, for instance, immortalize their elite through installation rituals in their halls of fame; sport teams ceremoniously retire their players' numbers. Religions engage in martyrology, creating monuments and holy days in remembrance of their founders and those having sacrificed their lives for the faith. Political regimes conduct similar rituals of remembrance with civil religion, conferring immortality with tombs for unknown warriors, statuaries, memorial days, and even postage stamps. Communist regimes, which battled religious legitimacy and proclaimed the finality of death, often embalmed their deceased leaders and put them on public display, as does the Catholic Church with its saints.

Conversely, regimes consign the memories of dissidents into political oblivion. Following the 1956 Hungarian revolt, the Moscow-controlled government in Budapest bulldozed the cemetery plots of the revolutionary leaders it hanged—including that of the former prime minister, Imre Nagy, who had urged democratization. Like the Roman Catholic and Orthodox churches, there can be intercessions on behalf of the deceased. In the 1970s, the U.S. Congress restored the citizenship rights of Robert E. Lee, and 18 years after his death, Nobel Prize–winning Boris Pasternak was posthumously reinstated into the Union of Soviet Writers.

The Microscopic Perspectives of Sociology

In addition to the macroscopic perspectives, sociologists have long studied death at the personal level, analyzing individuals' death-related beliefs (such as attitudes toward abortion, euthanasia, suicide, and capital punishment or beliefs in an afterlife), the social sources of their death fears, and the social status of (and interactions with) the dying and their caretakers, the dead and their survivors. People's ideas and fears of death are not innate but rather learned from their social and cultural environments. Dying is as much a social process as it is a biological or psychological one. In developed countries, death fears are increasingly acquired not so much through firsthand experiences as they are such secondhand sources as the media.

The Social Status and Experiences of Those Who Die or Are Most Likely to Die

To minimize the social disruptiveness occasioned by their deaths, the status of the dying (at least those normally perishing due to "natural causes") is often minimized, their full personhood denied. This is particularly true in modern death-denying cultures, in which AIDS victims and the elderly are stigmatized and must counteract others' tendencies to treat them as death lepers.

Medical sociologists have analyzed the interactions between the terminally ill and family members, clergy, and medical practitioners. Studies have consistently shown that physicians (who have been found to have inordinately high death fears when compared to other professionals and whose medical school training in dying is limited) often believe that the terminally ill do not want to know about the severity of their situation, that such information would destroy all hope and thereby accelerate death. A majority of patients, on the other hand, do wish to be told the truth and feel betrayed if the information is withheld. Glaser and Strauss modeled this as an informational game where, for instance, terminally ill patients know their fate but play along with the deceptions of medical staff and families and act as if all is well.

From military sociologists come studies of transforming civilians into warriors and later from warriors (i.e., those who have killed and have seen the war's carnage) back into civilians. The transitions are not easy. Soldiers are trained to kill and to be killed. Homicide rates have been found to increase following the conclusion of war but only within the victorious nations.

The Stigma Associated With Dealing With Death, the Dying, and the Dead

In India, the task of disposing of the dead is reserved for those at the bottom of the caste structure. In the West, particularly in England and the United States, the attempts of funeral directors and embalmers—whose members often come from the working class—to be recognized as professionals (perhaps as "grief experts" or funerary orchestrators) is a telling story. Among physicians, connections with the dying diminish one's status within the prestige hierarchy of the profession.

Those who must directly deal with death—such as medical pathologists, homicide detectives, forensic pathologists, animal slaughterers, death-row wardens, and hospice workers—are also subjects of sociological studies. These individuals have been found to distance themselves from their grim trades through viewing cadavers akin to the shells of cicadas and through using humor.

Grief, Bereavement, and the Social Status of Those Who Survive

With individualism and individuals' diminished connections with supportive communities, the brunt of death is borne by fewer and fewer people, whose loss is decreasingly public and must bear the burdens of loss alone. Symbols of mourning, such as the black mourning garbs of Victorian widows or the black arm bands worn by men, have largely disappeared. The period of mourners' exemption from social responsibilities has contracted significantly over the past century. Emily Post noted in 1927 a 3-year period for formal mourning; 5 decades later, Amy Vanderbilt recommended resuming normal life 1 week or so following the funeral. Legitimate grief and bereavement are not always socially recognized, compounding the emotions of loss. Issues of disenfranchised grief have emerged, such as with the loss of a life partner in a same-sex relation.

The burden of grief, like the care for the dying and traditional preparations of the dead, disproportionately falls on women. Their bereavement status in many preindustrial cultures often requires acts of self-mutilation, such as the severing of a finger or, in the extreme, the Indian practice of suttee, in which the widow is expected to sacrifice herself on the funeral pyre of her husband.

Legacy Work

No understanding of sociological insights into death and dying would be complete without including patterns of inheritance. The upper classes have long engaged in ways to be posthumously acknowledged, their names preserved with Roman numerals through progeny and adorning buildings, philanthropies, and foundations in support of various causes. With many elderly persons outliving their life savings, one traditional mechanism for assuring their assistance and care in advanced old age by family members is evaporating. Estate lawyers report growing desire of clientele to posthumously control the activities of the living through incentive trusts.

Michael Kearl

See also Aging, the Elderly, and Death; Genocide; Homicide; Social Class and Death; Suicide; Symbolic Immortality; War Deaths; Widows and Widowers

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Death Anxiety

Long the focus of spiritual belief and philosophical conjecture, death and the attitudes of human beings toward it have become legitimate topics of psychological study since the middle of the 20th century. As ways of measuring death fear and anxiety have grown more sophisticated, and as the range of people studied has grown more diverse, researchers have produced a sizable scientific

literature on the causes, correlates, and consequences of death anxiety and related responses. Ultimately, this work has begun to yield practical implications for such contexts as death education for school children and professionals, medical and institutional care for the infirm, and even social criticism of mass movements, such as the response of large groups of people or political parties and governments to war or terrorism.

The study of death attitudes has a long past but a short history. Rooted in religious and philosophical systems that are as old as recorded human thought, the focused psychological study of attitudes toward death began only with the research of Herman Feifel in the 1950s, steadily gaining momentum thereafter. Reflecting the abiding themes of the "death awareness movement," early research focused on assessing fear of death and anxiety in relevant groups such as older adults and physicians, arguing that the discomfort reported by participants stemmed from a blend of individual factors (such as unconscious avoidance of personal mortality) and cultural attitudes (such as the American denial of death). Following the publication of Kübler-Ross's influential popular book, *On Death and Dying,* in 1969, research on death attitudes burgeoned, supported by publication of the first validated scales of death anxiety and related constructs. The result was a literature that became more methodologically sophisticated, more topically diverse, and ultimately more practical in its applications.

The Problem of Measurement

Early research on attitudes toward death used a patchwork of straightforward interviews; fantasy measures, such as asking participants to draw an image of death that was then rated for its positive or negative emotional tone; and projective tests, such as ambiguous death-related pictures to which participants would tell a story that could vary in its plot and theme. Among the most interesting of these methods were those that sought to assess perceptual defense by use of the Stroop color–word interference test, which flashed death- and nondeath-related words (such as *cancer* or *basket*) in different colors, with the instruction that the participant should quickly name the color; delay in doing so for the death-related words relative to the controls was taken as a measure of unconscious defense against the threatening perception of death, which could then be related to such factors as participants' gender, age, or medical status. Few of these variables, however, converged to yield coherent findings within or across studies, and few were carefully assessed for their reliability or validity in separate research.

By the mid-1970s research on death attitudes had increased in sophistication: Carefully constructed questionnaires were designed to assess global death anxiety, the threat that personal death posed to one's sense of identity as a living being, and the fears people reported concerning the state of death versus the process of dying as these centered on one's personal mortality versus loss of another. In the years that followed, instrument development continued, yielding reliable multidimensional measures of more subtle aspects of negative death attitudes, such as fears of premature death, concerns about bodily deterioration, anxiety about a protracted and painful dying, fears of nothingness or divine punishment, and worries regarding the impact of one's own death on loved ones. Finally, researchers began to recognize in their formal measures that death attitudes were not limited to a fearful preoccupation with mortality but also could include active behavioral avoidance, neutral acceptance of death as a part of life, and even active embracing of death as a form of surcease from a painful world or positive anticipation of an afterlife of reward. As a result, researchers are currently in a much better position to study how people actively process the reality of death in human life and relate it to other factors of theoretical or practical relevance.

Correlates of Death Anxiety

With the completion of literally thousands of studies of death anxiety in recent decades, some reliable trends have emerged in the findings, as well as many unanswered questions. Some findings are predictable: Professional groups that involve greater *risk* of death (such as firefighters or soldiers) tend to report greater death fear than do those who simply confront higher degrees of death *exposure* (such as physicians or funeral directors). Likewise, both physical and mental illness are associated with more anxiety about

personal mortality, and religious belief, though not necessarily religious behavior (such as attendance at services), often but not inevitably predicts higher death acceptance. In contrast, some findings are counterintuitive or largely unexplained. For example, older adults as a group are not more fearful of death than younger cohorts, despite their greater statistical proximity to death; if anything, death fears seem generally to peak in midlife. For whatever reason, women commonly acknowledge greater discomfort with death than men, a finding that tends to hold across ethnic and cross-cultural comparisons and that does not appear to be explained by a greater female penchant for emotional self-disclosure or a masculine concern with the social desirability of responses. Thus, more remains to be learned about even the more frequently replicated findings in the published literature.

Experimental Studies

Although correlational and group-comparison studies are informative, they are also limited in the sense that they cannot identify the causes of death attitudes, and they cannot reliably determine their effects. For example, knowing that psychiatric patients have a higher level of death anxiety than "normal" controls leaves open the explanation of this finding: Perhaps their fears of death contribute to their more general angst, as existential philosophers might suggest; perhaps their general anxiety simply "spills over" into worries about death and dying; or perhaps both general and death-specific anxiety are the result of other, more basic factors, such as attachment insecurity or problems in emotion regulation. To provide more definitive causal explanations for attitudes toward death, researchers need to conduct genuinely experimental studies that control some variables while manipulating or changing others and then carefully measure the effects. Two major lines of research on death attitudes have followed this strategy with useful, if sometimes disquieting, results.

The first is a long line of research by many investigators on death education, a diverse curriculum for grade school, high school, and college students as well as professionals, focusing on understanding the dying process, on cultural practices regarding death and bereavement, on demographic trends in dying and on a variety of specialized topics, such as suicide, problems of contemporary institutionalized dying, and stresses and skills in working in end-of-life settings or in grief therapy. In general, participants in such educational programs, relative to comparison groups, have developed a greater knowledge of death and dying, as one would logically expect. At an attitudinal level, however, results have been more mixed, with educational programs featuring primarily lectures and readings often *increasing* death-related anxieties, whereas those featuring experiential learning more commonly *decrease* such fears. It therefore seems that if one goal of such education is to allow people to approach death-related discussions and situations with greater equanimity, then ample opportunity should be provided for personal processing of the curriculum through subjective values exploration, group exercises, and reflective writing.

The second major experimental program of research concerns *terror management,* the psychological process by which people unconsciously moderate their fears of death through engaging in behaviors that boost their self-esteem or strengthen their identification with cultural worldviews that provide a kind of "buffer" against personal mortality. In a typical study participants first would be exposed to either a *mortality salience* manipulation, such as being asked to complete their own death certificate, watch a film on traffic fatalities, or read material that highlights the frailty or vulnerability of the human body, or be assigned a neutral task, such as describing their dormitory room. They would then immediately engage in an unrelated activity, such as responding to a series of mathematics problems, to distract them from consciously attending to their resulting feelings or thoughts. Finally, they would be assessed for the predicted attitudes or behaviors theorized to defend against death anxiety, such as more favorably evaluating their performance relative to that of others or adopting more conservative political positions. Results of terror management research have been consistently provocative, demonstrating that confrontation with death can drive a wide range of social attitudes and behaviors, from recommending harsher punishment for drug offenders to xenophobic avoidance of people who are culturally different, both of which indirectly reinforce mainstream

cultural beliefs at the expense of others. Moreover, some of the results are paradoxical: Young men whose self-esteem is reinforced by aggressive driving may actually drive more recklessly after exposure to a curriculum on motor vehicle accidents, and college students may be more prone to practice unprotected sex following a presentation on AIDS, as if to flaunt their personal invulnerability. Such findings obviously have practical implications for a wide range of social interventions and contexts, including death education. It also could have relevance for understanding broad societal responses to events like high-profile terrorism, which can precipitate massive shifts toward conservative social and political attitudes and associated behaviors, ranging from increased participation in religion to advocacy of military retribution against parties or nations perceived to be responsible.

The Practical Yield of Death Anxiety Research

Although some studies of death anxiety seem to have been conducted simply for the benefit of the investigator, contributing little of value to our understanding of the human encounter with death, other research programs have yielded conclusions of clear practical value. One example is research on attitudes toward older adults, which suggests that people—including the staff of nursing homes—who are insecure about their own deaths are especially prone to derogate and devalue the elderly. Furthermore, an ample line of research has examined the predictors of heightened fear of death among older adults themselves, demonstrating that greater anxieties characterize those who live in institutional settings, who are seriously ill, and who struggle unsuccessfully to achieve "ego integrity," that is, the sense that they have lived well, fully, and authentically. Similarly, research on hospice patients suggests that those who enjoy social support, who have recourse to spirituality in their daily lives, and who are troubled by few regrets about their pasts or their foreshortened futures are able to approach death with greater equanimity. Such findings carry implications for psychosocial interventions with such groups, suggesting the usefulness of opportunities for life review and the development of compassionate acceptance of self and others.

Future Directions

Although the great upsurge of interest in death anxiety associated with the 20th-century death awareness movement has begun to wane, it seems likely that research in this area will continue to make a consistent contribution to psychosocial theory and applications and that, in many respects, the scope of this research will continue to grow as it encompasses other populations. One illustration is the study of death attitudes of children and adolescents, which makes creative use of artistic and narrative methods (such as drawing pictures of death as a personified figure or writing paragraphs about personal meanings of death) that are then subjected to careful analysis to reveal developmental trends in boys versus girls. Another example concerns the increasing diversity of populations studied, which have extended far beyond the home base of this research in American college students to include health care workers, schoolchildren, and medical patients in a wide range of Eastern and Western nations, such as Israel, Sweden, Spain, Egypt, Kuwait, Australia, and China. Such work holds promise of clarifying trends in death attitudes that transcend a single culture, such as the tendency for death imagery to become less violent and concrete with greater maturity, as well as findings of particular relevance to a given culture, such as the identification of distinctive fears associated with bodily torture in the grave (e.g., among people in Islamic countries), or heightened separation concerns regarding the death of another (e.g., among ethnic Chinese). In summary, the study of death anxiety represents an abiding and increasingly sophisticated and practical field of research in thanatology, one that can be expected to continue for some time to come.

Robert A. Neimeyer

See also Adulthood and Death; Aging, the Elderly, and Death; Death Awareness Movement; Death Education; Denial of Death; Terror Management Theory

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Death Awareness Movement

The death awareness movement refers to a somewhat amorphous yet interconnected network of individuals, organizations, and groups and includes scholars, advocates, and counselors. It encompasses self-help networks like The Compassionate Friends and professional associations such as the Association for Death Education and Counseling; the American Academy of Bereavement; the International Work Group on Dying, Death and Bereavement; and the National Hospice and Palliative Care Organization as well as their members, affiliations, and regional and state associations. Most hospices and palliative care units would identify with it, as would many funeral service organizations. Foundations such as the Hospice Foundation of America are involved as are varied institutes and interorganizational committees and task forces. Many larger organizations, with far broader and diffuse memberships and goals, may focus some attention on end-of-life issues and research or education on dying and death. For example, the American Psychological Association has a specialized task force on end-of-life issues. While the individuals involved may contribute to a variety of professional journals, there are a number of scholarly journals (e.g., *Omega, Death Studies,* and *Loss, Grief & Care*) as well as newsletters (e.g., *Journeys, Thanatos,* and *The Forum*) that focus exclusively on issues of dying, death, and loss.

In addition, the movement is international in scope. Many nations outside the United States and Canada have similar organizations. For example, the National Association for Loss and Grief serves Australia and New Zealand. The journal *Mortality* is published in the United Kingdom while *Grief Matters* hails from Australia.

The movement hosts teleconferences, symposia, conferences, workshops, and trainings and publishes a plethora of literature annually that ranges in audience from children to adults and from inspirational to self-help to serious clinical or scholarly work. This amorphous and far-reaching network—in reality a social movement—shares a common focus though not necessarily common goals, models, or methods. That focus is dying, death, and bereavement.

Roots of the Death Awareness Movement

The roots of the death awareness movement are diverse. Herman Feifel offered a seminar on death in the 1956 annual meeting of the American Psychological Association that later led to his landmark book, *The Meaning of Death*. Though there had been some significant theoretical and empirical studies prior to that work (by Sigmund Freud in 1917 and a generation later by E. Lindemann in 1944), Feifel's pioneering efforts are often regarded as the beginnings of a sustained academic study of death. The 1969 publication of Kübler-Ross's *On Death and Dying* increased public awareness of death. Throughout this period, a number of colleges began to develop and offer courses related to death and dying. These courses were housed in a number of different departments, including nursing, sociology, psychology, health education, or religious studies.

Death education continues to be consolidating. In addition to developing and offering courses, colleges and universities are now developing majors, certificates, and even master's degrees in grief counseling or thanatology. The Association of Death Education and Counseling has reinstated an earlier process for certifying death educators and grief counselors. Already, some members representing colleges and universities that have formalized programs have begun to discuss accreditation. These programs have been supplemented by academic centers such as the Center for Death Education and Research at the University of Wisconsin–La Crosse. Though this growth is impressive, recent events continue to suggest the tenuous nature of such

courses in the curriculum of universities and colleges. Many of these courses, programs, and centers are still tied to individuals rather than to departments or colleges. When a professor retires, the course or even the program may be retired as well.

In addition to this growth of academic thanatology, there has been a parallel growth in the period in the self-help movement. Since the early development of widow-to-widow groups, some groups such as The Compassionate Friends (a group for bereaved parents and siblings) have focused primarily on bereavement support, whereas others, such as Mothers Against Drunk Driving or Parents of Murdered Children, have included bereavement support along with other issues such as legal advocacy. Recent studies have emphasized that such support can be helpful to those both giving and receiving assistance.

The Development of Hospice

The major organizational effort in the death awareness movement is the development of hospice. That movement's remarkable history is well noted in other sources. It was, perhaps, one of the most successful grassroots movements in the last quarter of the 20th century. While the hospice movement has its roots in religious orders such as the Knights Hospitallers and the Sisters of Charity, both of whom focused on caring for the dying, Dame Cicely Saunders is generally credited with opening the first modern hospice, St. Christopher's, outside London in 1967. St. Christopher's tried to create a "homelike" atmosphere that sought a holistic, family-centered way to allow dying persons to live life as fully as possible, free from debilitating pain and incapacitating symptoms.

St. Christopher's became a beacon of research and practice, generating seeds that would grow throughout the world. Many of the pioneers who would influence the development of hospice and palliative care visited or trained there.

In the United States this resulted in the development of Hospice, Inc., outside of New Haven, Connecticut, in 1974. Branford, Connecticut, also had a small home care unit. But it was Dr. William Lamers, a founder of a hospice in Marin County, California, that viewed home care as both the heart and future of hospice. To Lamers, the idea of a homelike environment could best be offered within the patient's actual home. This home care model freed interested individuals from fundraising for new facilities and quickly spread throughout the country, sponsored by a range of groups from churches and interfaith groups to junior leagues. Hospice then took a very different cast in the United States, then in England, centering more on home care and heavily emphasizing psychosocial care and the use of volunteers.

The success of hospice was impressive. In 1974, the National Hospice Organization was formed. By 1978, there were over 1,200 hospices. In 1982, hospices could receive Medicare reimbursement. This proved a further spur to growth. There are now estimated to be over 3,000 hospice programs serving 700,000 persons annually.

The growth of hospice was a reaction to a number of trends. First, technology-driven medicine focused on cure, seemingly abandoning those who were no longer responsive to treatment. Second, hospice resonated with two other themes of the era—"consumerism" and "return to nature." Both trends converged on the idea that individuals could create alternative, more natural organizations, that they could take control of their lives—and their deaths. The study of death, especially the popularity of books like Kübler-Ross's 1969 *On Death and Dying* increased awareness of the unmet needs of the dying and bereaved.

Not everyone learned the same lesson at St. Christopher's. St. Christopher's impressed Dr. Balfour Mount, a Canadian physician; however, Mount was convinced that the lessons of St. Christopher's need not necessarily lead to a new form of care, but could be applied even in the high-technology environment of the modern hospital. When Mount returned to the Royal Victoria Hospital in Montreal, he pioneered the development of a hospital-based palliative care model. This model was further developed, and by the turn of the century the National Hospice Organization changed its name to the National Hospice and Palliative Care Organization to reflect these two different approaches, both centered on providing more humane care to the dying.

Current Status of the Death Awareness Movement

At present, the death awareness movement has become relatively institutionalized. This is evident

in a number of ways—many funeral homes now routinely offer "aftercare" services, ranging from informational and referral to educational seminars to sponsoring counselors and groups. Large-scale educational events are not uncommon: Bill Moyers's documentary series *On Your Own Terms* and Mitch Albom's book *Tuesdays With Morrie* (as well as the film adaptation) focused on death and dying and received widespread critical acclaim and public attention. Each year, the Hospice Foundation of America produces a major *Living With Grief* teleconference that reaches over 2,000 sites throughout North America and offers education to nearly 250,000 professionals. It is now routine, in situations of death and loss, to send crisis teams and grief counselors. In fact, President Clinton's response to the shooting of 12 students and 1 teacher by 2 classmates at Columbine High School in 1999 was to reassure the nation that he had dispatched grief counselors to the site.

In the mass media, dying and death are no longer taboo topics. News programs such as *60 Minutes* and *Dateline* frequently feature stories related to death and dying. At events such as the death of John F. Kennedy Jr. or in the aftermath of the September 11, 2001, attacks, it was not unusual to see in print and nonprint media grief and trauma experts discussing common reactions to the events and offering advice. The topic of death and dying has even appeared in the entertainment world, for example, in HBO's critically acclaimed *Six Feet Under,* a television series that took place in a funeral home and frequently showed expressions of grief, funerals, and corpses.

Reaction to the Death Awareness Movement

Naturally, such a movement has generated reaction. For example, in the aftermath of Columbine, there were a few critical pieces in the popular press that challenged the value of grief counseling. There has been a small reactive movement against death education in schools, spearheaded by anti-ERA activist Phyllis Schafly. R. Rosenbaum led a scathing attack in *Harper's*. To Rosenbaum the death awareness movement, led by Kübler-Ross, seeks to create a cult of the dead, romanticizing the process of dying and encouraging suicide. Rosenbaum's piece mixes serious cultural criticism with personal attacks on Kübler-Ross, who, at this juncture in her life, had begun to explore spiritualism. What Rosenbaum neglects to realize or to state was how distant the death awareness movement, at least within academia, had become from this former icon.

In essence, the contemporary criticism echoes an earlier, academic critique, labeling those as members of "the happy death movement" and accusing them of attempting to offer a positivist view of death that romanticizes dying and overemphasizes emotional expressiveness as therapy for the dying and bereaved. It might be stated that many of these reactions, while they do speak to some of the strains of popular thanatology, vastly oversimplify the many approaches and rich theoretical debate evident within the death awareness movement. In any case, the movement's place in academia, health care, self-help, and popular culture seems secure.

Factors Underlying the Development of the Death Awareness Movement

Beyond simply reviewing the chronology of the death awareness movement, it is interesting to speculate on some of the factors that influenced the easing of cultural taboos on death and the emergence of the death awareness movement. At least four major factors seem to be germane to this discussion.

The first factor involved changing demographic considerations. As the proportion and population of the elderly have increased, interest in the field of aging has intensified. With the study of aging has come an increased awareness and study of dying and death. The prolongation of death has created new strains for medical staff, new ethical issues, and new forms of care, all of which have served to increase public awareness of and interest in the discussion and organization of dying and death.

The second factor is historical. Many researchers have noted that the beginning of the nuclear age has created totally new issues that have complicated death and increased death anxiety. The latter half of the 20th century and beginning of the 21st have raised other issues. In this era, we have become aware of danger to the environment. We have the ever-present threat of worldwide

terrorism. We have seen the emergence of a new disease—AIDS—that has devastated communities in the Western world and continues to decimate Africa and threaten other developing areas. Faced as we are with the possibilities of the nuclear death of civilization, new diseases with environmental holocaust, and random terrorism, death has become a critical social concern. Support for this perspective can be found in the case of the late Middle Ages, when the widespread devastation caused by bubonic plague was reflected in a preoccupation with death, as evidenced by the art, religion, and popular thought of the time.

The third factor associated with the apparent rise in death awareness is sociological and social psychological in nature. The death awareness movement was aligned in goals with many of the social movements and trends of the 1960s. It asserted the rights and dignity of the dying. It proclaimed the naturalness of death. It denounced dehumanizing technology. It emphasized openness toward death and sharing with the dying. In short, its increasing popularity during the decade was aided by its identification with many social themes evident at that time.

The fourth factor is cultural. The death awareness movement filled a void in a secular society in which many segments of the population found no significance in the past's understandings of death within our culture in a manner that was more acceptable and thus more meaningful. In a society that is materialistic, death was avoided or denied. The death awareness movement then was part of a broad trend toward the inclusion of spirituality and meaning-making. That probably emerged as an increasing number of the baby boom generation contemplated the mortality of their parents as well as their own mortality.

Conclusion

This does not mean to suggest that the death awareness movement is merely a fad or a relic of the 1960s. While a number of factors combined in this era caused the movement to emerge and grow, it has demonstrated respectability and durability. It has become institutionalized. In fact, as members of the baby boom generation age, their own historical way of actively confronting the issues they face and compelling the larger society to face them suggests that they do.

Nor does it mean that the present forms will remain as they are. It will be interesting to see, for example, the ways that the growth of palliative care as well as other changes in U.S. health care will affect the future of hospice. Moreover, there are increasing calls to evaluate the effectiveness of grief counseling. There is danger that untested and unevaluated approaches that lack theoretical depth can do the movement great harm. Yet, even here, there are promising trends. As fields develop, there tends to be a consolidation of knowledge and a move toward certification.

One can predict in the next few decades an intensified interest in death and dying and increasing growth of the death awareness movement. Part of this is simply momentum. The development of large self-help networks, hospices, professional associations, and other organizational efforts, as well as the development of certification and educational programs in the area of death and dying, suggests continued focus. In short, interest breeds more interest.

Another part, though, is generational. The baby boom generation is now at the verge of moving into later life. As the baby boomers age, their own characteristic way of confronting the issues they face and compelling the larger society to do so suggest that death will continue to be a topic of interest well into the 21st century.

Kenneth J. Doka

See also Grief and Bereavement Counseling; Hospice, Contemporary; Hospice, History of; Kübler Ross's Stages of Dying; Palliative Care; School Shootings

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Deathbed Scene

Deathbed scenes are representations of the end of some person's life. The person may be real or fictional, and the presence of an actual bed is symbolic rather than necessary. What it reinforces when present is the comparatively extended nature of the death process. In this respect, deathbed scenes contrast with scenes of sudden death. In clear cases of sudden death, the dying person has no protracted opportunity to reflect upon his or her life. Deathbed scenes depict a more reflective process. The dying person must be awake and sufficiently in possession of their faculties to reason instructively about their predicament.

The most famous deathbed scene is set out in Plato's dialogue, the *Phaedo*. Faced with the prospect of his own demise, Plato depicts Socrates shunning any temptation to despair and maintaining a cheerful equanimity. His sends away his weeping wife and engages in an ultimately inconclusive but engaging dialogue concerning death and the likelihood of an afterlife. There is no fetishization of dying well as something apart from ordinary conduct. In the absence of any guarantees about the future, Socrates ends his life in a way that affirms its worth.

Socrates' deathbed scene has parallels in biblical and rabbinical literature, where a dying sage or patriarch gives a final parting lesson to his disciples. Occasionally there is an element of conflict and role reversal, with the dying man being instructed and set on the right path through dialogue with someone present at his death. This recurring theme of dying well and its association with the deathbed is present in a more structured and regulated way in late medieval and early modern Christian texts. As well as placing more formal requirements on the dying person (the *moriens*), there is a greater emphasis on the theme of conflict and being torn. The deathbed scene represents a time of crisis and struggle, as devils and angels vie for possession of the soul. The death of each person is to be, on a small scale, an *imitatio Christi* as the worldly and the spiritual are torn apart.

The earliest dedicated text in this Christian tradition was the *Ars Moriendi* (The Art of Dying), written by an unknown cleric and published around 1450 and frequently republished for 2 centuries thereafter. The text gives guidance on how to die well in the presumed absence of a guiding and counseling priest. The woodcuts accompanying the text depict contrasting temptations and inspirations that surround the *moriens*. The temptations are disbelief, despair, impatience with suffering, pride, and avarice. For every deathbed temptation, there is assistance available. The reader is offered hope rather than terrifying, *macabre* depictions of damnation.

What seems to be a departure from earlier, pre-Christian and pagan traditions is that suicide (which plays a part in both the death of Socrates and later in accounts of the death of the Roman philosopher Seneca) now seem to be ruled out, not so much as a rejection of despair, but as a rejection of impatience with suffering. Death is to be waited for with patience.

The impact of early modern Puritanism on this tradition of deathbed instructions involved a questioning of the efficacy of deathbed conversion and the pardoning of sins. A deathbed struggle for the soul presupposed a life that had been questionable

or straightforwardly sinful. But what need was there for a life of denial and constraint if the ledger books could be balanced with a few well-placed and sincere words at the end?

Questioning of the ars moriendi tradition also came from other, nonpuritan sources. In Shakespeare, the dying Falstaff is said to have mentioned sins and to have called out "God, God" but conspicuously made no ultimate confession and presumably won no final battle. The death of Othello similarly seems to play upon the limitations of the ars moriendi tradition. Othello dies badly, but his final failure is not that of succumbing to any of the temptations set out in the ars moriendi literature.

The last great exemplar of a tale of deathbed repentance concerned the notorious libertine, John Wilmot, the Earl of Rochester. In 1680 he is supposed to have issued instructions for full details of his faults and his ultimate repentance to be laid before the public. The credibility of this account of events has been questioned. In subsequent centuries accounts of the death of a succession of skeptics, free thinkers, and atheists, such as David Hume, Thomas Paine, and Charles Darwin, helped break the monopoly of penitent but orthodox Christians on dying well.

Although sentimentalized in Victorian literature and art (most notoriously by Dickens with the death of the character Little Nell in *The Old Curiosity Shop*), the deathbed scene remains influential in films and novels, even in news coverage and documentaries. A prominent example is the use of video diaries by dying patients to highlight some medical condition such as AIDS. In such cases the viewer gains only a fragmentary insight into the world of the dying. There is still the assumption that it is an occasion for a special kind of truthfulness. Occasionally, the ars moriendi tradition resurfaces in a straightforward manner, as it did in fragmentary media coverage of the apparently patient, nondespairing death of Pope John Paul II, who was afflicted with Parkinson's disease.

Tony Milligan

See also Art of Dying, The (*Ars Moriendi*); Depictions of Death in Art Form; Depictions of Death in Television and the Movies; Good Death; Literary Depictions of Death

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Death Care Industry

The death care industry consists of funeral homes, mortuaries, and other funeral providers who provide services for the dead as well as ways the living can honor the deceased. The death care industry around the world has evolved to serve the needs of the deceased and the bereaved, based on societal conditions, cultural proscriptions, and consumer demand.

Beginnings of the Modern Death Care Industry

The creation of the American funeral industry can be traced back to the circumstances of the American Civil War during which time transportation of the deceased back to his or her home without decomposition became very important. Methods to temporarily preserve the corpse were developed, although most Americans were not aware of these procedures and did not accept any "unnatural" intervention into the dead body's organic processes of decomposition. In time, the practice of embalming became more acceptable to Americans to ensure that they could have a last look at their lost loved ones with a pleasant appearance. These changes in the American funeral industry occurred as the end of the 19th century drew near. The industry gained economic power by the mid-20th century.

In other parts of the world, developments occurred along varying timetables. For example, the first Chinese funeral home was built by an

American in Shanghai around 1924. Chinese funeral homes began to spread in that area, as local apprentices learned the practice of embalming and knowledge about management from the owner of the American funeral home. After the Communist government came to power in China, all the funeral homes were taken over by and run by the government until the beginning of the 21st century. In developing countries like Taiwan, where there are both privately owned and government-owned facilities, the industry is no older than 30 years.

Prior to the development of the Chinese funeral industry, in 1880, the Japanese funeral companies originated in Tokyo, where they provided the service of lending funeral accessories to the bereaved and facilitating religious services for Shinto and Buddhist ceremonies, as well as arranging funerals and porters to carry the coffins. Since World War II, the Japanese funeral industry has developed along with other consumer services, following the economic development of the rest of the country.

The Death Care Industry Today

In the modern era, the death care industry is divided into three segments: (1) funeral (or memorial) services, which include pre-need planning and aftercare; (2) interment; and (3) grave memorialization. To adapt to societal changes and capture their share of the market, funeral directors have launched aggressive advertising campaigns; moved their operations into unconventional settings, such as shopping malls; and tried to shed their gloomy image using a variety of strategies, such as painting their hearses in colors other than black. Funeral directors have become more flexible, arranging services that accommodate personal choices, such as the scattering of ashes across lakes or mountains. Of all the changes in the funeral scene over the past decades, easily the most significant is the emergence of monopolies. Owners of funeral homes include individuals or families, local owners and smaller companies, corporations, and large chain companies in developed countries, such as Service Corporation International (SCI), which owns nearly 500 cemeteries. In contrast, in some developing countries like mainland China, the funeral industry is government supported.

Other than the consumer demands for more flexibility in funeral planning, the most significant societal factor to impact the death care industry in the United States recently is the country's declining death rate. This trend will change, however, due to the aging of the baby boom generation. A country's total industrial value of death care is determined by the number of people's deaths, its death rate, and the average cost of a funeral, burial, and monument. For instance, the death care industry provides more than 11 billion U.S. dollars in annual revenue and the average cost of a funeral service in 2004 was $6,500, according to the National Funeral Directors Association of the United States. But the cost of disposing of remains can range from far less to much more, depending on personal preferences and geographic context. For example, in China, annual revenue for the death care industry will be more than 30 billion U.S. dollars, and the average cost of a funeral service in 2006 was 360 U.S. dollars, according to the Statistics Bureau of China.

Standards of Practice and Oversight

Central to the ongoing development of the death care industry, including both the protection of the field and the protection of consumers, is the establishment of "learned societies" as well as national- and state-level regulations. The death care industry includes global, national, and local associations designed to best serve consumer needs and regulate the field.

Funeral Service Organizations, Associations, and Societies

The Society of Allied and Independent Funeral Directors exists to protect the interests of the smaller family funeral directing firms and their clients. There are many important funeral associations worldwide. The global association FIAT-IFTA (Fédération Internationale des Associations de Thanatoloques—International Federation of Thanatologists Associations) was founded in 1970 and is located in Monte Carlo, Principality of Monaco. The National Funeral Directors Association in the United States was established in 1882 and is the oldest and largest national funeral service organization in the world. The formal

name of the National Association of Funeral Directors in the United Kingdom was the British Institute of Undertakers, set up in 1898 by a group of funeral directors to "raise the status of the profession." The China Funeral Association, a national social organization of the funeral industry in China, was established in September 1989 and is engaged in funeral affairs under the leadership of the Ministry of Civil Affairs.

The objectives and purposes of these associations are as follows: (a) to research and jointly study issues relating to thanatological activities, especially with regard to services rendered in the memorialization and disposition of deceased individuals; (b) to promote international understanding and goodwill among funeral service professionals and to achieve uniform standards, rules, regulations, and treaties for the cost-efficient international repatriation of deceased individuals; (c) to encourage and develop education in the field of embalming, including establishing uniform standards and regulations; (d) to increase the level of professional knowledge of funeral service practitioners; and (e) to provide due respect and deference to the autonomy of national organizations and to avoid any interference in all matters pertaining to individual nations.

Funeral Service Education

Funeral service education aims to develop highly qualified funeral service professionals. The system in most countries includes schools, colleges, associations, and certification. To become a professional funeral director, a person has to attend a college or university program in funeral service or mortuary science education, pass the examination to get a certification, join a funeral directors association, and get certification credits. The program's courses includes coffin and casket manufacture, funeral operations, embalming, occupational health and safety, infection control, basic and advanced mortuary skills, restorative art, mortuary cosmetics, transfer procedures and guidelines, grief in the funeral workplace, ethical values for funeral service, funeral ceremonies, and laws about death. Certification credits are a new professional development requirement in the United States, to help funeral service professionals stay well-informed and up-to-date. The Academy of Professional Funeral Service Practice (APFSP) provides a voluntary certification program to funeral service practitioners. Credit is awarded in one of three categories: academic, professional funeral service, and civic. Members of APFSP are also allowed the opportunity to earn retroactive credit for activities in which they were involved from the date of licensure to the date of joining the academy.

The American Board of Funeral Service Education was founded in the 1940s and is recognized as the sole national accrediting agency for academic programs that prepare funeral service professionals by the U.S. Department of Education and the Council on Higher Education Accreditation. There are three other representative associations in the United States: the National Funeral Directors Association, the National Funeral Directors and Morticians Association, and the International Conference of Funeral Service Examining Boards.

Death Care Industry Sites of Service

The Funeral Home

Funeral homes provide many services for the consumer, including arranging all of the details for a memorial service and providing services after the funeral ceremony, which are often referred to as aftercare or grief support. Funeral home services normally include the funeral director's services, attending arrangements, a coffin suitable for cremation or burial, transfer of the deceased from the morgue to the funeral home, care of the deceased prior to the funeral, a hearse to the nearest crematorium or cemetery, the choice of day and time for the funeral to take place, embalming, viewing of the deceased, and provision of a car or limousine.

Funeral Director

After discussing customers' requirements, funeral directors will do many tasks, which can be grouped according to services prior to the funeral ceremony, during the funeral ceremony, and after the funeral ceremony.

The funeral director's duties include making arrangements for the funeral service, such as embalming, dressing, casketing, and cosmetics. Funeral directing and embalming are licensed separately by local jurisdictions. The job is also known as a mortician or undertaker: A mortician

is a person who works in a mortuary, and an undertaker was the name given to those who were able to undertake funerals as a part of their work in the United Kingdom. In modern times, the term *funeral director* is most commonly used for the person who performs all of these functions.

Pre-Need

During the 1980s, a method of funeral planning was developed, in which a funeral home helps relieve people's difficulties in making decisions at the time of death through planning their own funerals, designating their funeral preferences, and sometimes even paying for them in advance. This planning is called "pre-need funeral arrangements," "prepaid funeral agreements," or "pre-need." In this era, there is a greater willingness to take charge of one's own or a loved one's planning prior to death. It uses a similar process as an existing life insurance policy to pay for their funerals in advance. During the funeral planning, one is able to decide what type of funeral one will have, choose the specific items desired, write the will and estate planning, compare the prices offered by several funeral providers, and perhaps "lock in" today's funeral prices for the future, thus eliminating some of the stress that family members frequently experience.

To avoid the possible abuses of pre-need arrangements and to protect consumers who pay for their funerals in advance, regulations of pre-need funeral agreements between funeral directors and consumers have been developed. U.S. Congress enacted the Preneed Act of 1993 to strengthen existing laws. That means consumers should ask the funeral director for two things: (1) the Statement of Funeral Goods and Services, which details the goods and services the consumer is purchasing, for instance, what type of urn will be used for the burial, and (2) the Prepaid Agreement, which briefly describes the conditions and terms of the agreement, including the amount of money paid and any additional funds owed.

Disposal of Human Remains

Human remains are usually disposed of via burial or cremation. Burial is the act of placing a dead person in the ground and is also called *interment* or *inhumation*. The remains are buried so as to protect them, including hiding them from removal or tampering. Burial practices come from the human desire to show respect for the dead. Reasons for burial include respect for the physical remains, deemed necessary by the deceased's family and friends in many (but not all) cultures; an attempt to bring closure to lessen the pain of losing a loved one; and perhaps a necessary step for the deceased to reach the afterlife, in which case certain religions or customs prescribe a preferred or required method for disposing of the dead.

The World Health Organization declares that only corpses carrying an infectious disease require burial. After death, a corpse will start to decay and emit unpleasant odors due to gases released by bacterial decomposition. Burial prevents the living from having to see and smell the decomposing corpse, but it is not necessarily a public health requirement.

Humans are not always buried. Alternatives to burial include cremation, ash jump for skydivers, burial at sea, funerary cannibalism, ecological funeral, excarnation, gibbeting, hanging coffins, sky burial, and space burial. In most cases these alternatives are still intended to maintain respect for the dead, and some are intended to prolong the display of the remains.

In the cremation process, the deceased is burned in a crematorium. Most of the body is incinerated, leaving only pounds of bone fragments, which are processed into a fine powder called ashes, cremated remains, or cremains.

As opposed to traditional burial, cremation offers much more flexibility in dealing with the remains and has become a popular choice in Eastern countries such as in China and Japan, as well as in some Western countries. Cremation is now government required in mainland China. Options for the cremated remains include keeping the ashes in a container (called an urn) at home or at a temple, or scattering the ashes at a place of importance to the deceased, usually outside. Cremated remains can also be buried underground or in a columbarium niche. In the Eastern world, ashes may be interred into existing plots owned by the family.

For traditional burials, a coffin or a casket is used for placement of the corpse. This funerary box is used to both contain and display the remains of the deceased. A coffin may be buried in the ground directly, placed in a burial vault, or

cremated. The above-ground burial is in a mausoleum—generally a cement building at a cemetery that houses hundreds of bodies—or a small personal crypt.

Cemeteries

A cemetery is a place where dead bodies or cremated remains are buried. The term *cemetery* means "sleeping place," originating from the Greek word κοιμητήριον, which implies the land is specifically designated a burying ground. Cemeteries are places where the final ceremonies of death are observed in most of the world. However, these rites or ceremonies vary according to cultural practice and religious belief.

Memorializing the Deceased With Memorial Markers

When someone loses a loved one to death, a variety of reactions called grief are experienced. Funeral and burial traditions including a gravesite and a memorial marker serve the dual purpose of both memorializing the deceased as well as providing a vehicle for the expression of mourning by the bereaved.

Memorialization can be expressed through different modalities, such as putting a special headstone marker on the grave of the deceased, ordering a personalized funeral urn for the deceased, or planting or placing a memorial tree or stone.

Aftercare or Grief Support

Funeral home aftercare, grief support, or a continuing care program can be provided by a funeral home to maintain a helpful and caring relationship with clients, offering continuing services to the bereaved. Aftercare providers may provide aftercare programs that are staffed by skilled bereavement care providers. Most aftercare programs include some combination of individual counseling, grief support groups, a lending library, remembrance services, newsletters, community death education, and life planning seminars.

The death care industry is an evolving industry with similarities across international borders and unique regional features for the provision of services to both the deceased and the bereaved. This industry serves a vital function in helping humans show their ultimate respect for the value of life, which is in the manner in which it takes care of the deceased.

Tom Tseng and Chia-shing Su

See also Death Care Industry, Economics of; Funeral Director; Funeral Industry; Funerals and Funeralization in Cross-Cultural Perspective

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Death Care Industry, Economics of

The Standard Industrial Classification used by the U.S. Department of Labor describes the death care industry as "establishments primarily engaged in preparing the dead for burial, conducting funerals, and cremating the dead." There are approximately 22,000 funeral homes and 7,500 commercial cemeteries in the United States. However, the death care industry has a number of different components in addition to funeral homes and cemeteries, including monument makers, crematories, casket and urn manufacturers, producers of

memorial merchandise, pre-need sales, and cremation disposal operations. Furthermore, there are peripheral vendors that include funeral software designers, web technicians, insurance and trust companies, and marketing agencies, all of which support firms involved with direct contact with the dead and the bereaved. Oftentimes there is a great deal of overlap with regard to these different components. This is especially true for funeral service corporations, which typically offer economies of scope by offering a wide range of services and products.

Regulation of this industry varies from state to state, with the exception of the Funeral Rule. Under this mandate by the Federal Trade Commission, firms must make explicit particular pieces of information, such as an itemized price list. The mandate also prohibits certain claims, such as that embalming is required.

Financial Crises

Throughout most of its 150-year history, the death care industry legitimated its role in society contributing to the general social welfare. In the early stages of the industry's development, the protection of public health and sanitation was offered as justification for services and goods. Once restoration techniques and chemicals had sufficiently developed to transform the dead into aesthetically pleasing memory pictures, the industry expanded its role to include the facilitation of grief therapy. Beginning in the 1990s a series of events led to a crisis of capital accumulation for the death care industry that resulted in a shift in the way the industry framed its functions for society.

There are a number of contributing factors to this economic change. Jessica Mitford, who had originally written a scathing and widely read critique of the death care industry in 1963, died. Her passing, in combination with a release of a new edition of her book *The American Way of Death* in 1998, inspired many in the mainstream media to investigate cost issues and report on exploitative practices.

Another factor that contributed to the financial crisis during this time was the declining death rates. North Americans continued to live longer lives, and members of the baby boom generation (i.e., those born between 1946 and 1964) were only beginning to bury their parents. Because the annual number of U.S. deaths (between 2.3 and 2.4 million per year from 1993 to the present) and the number of U.S. funeral homes remained relatively stable (a little over 20,000), there were insufficient increases in customers to offset simultaneously increasing fixed and variable costs.

Finally, as was made famous by the popular HBO TV series *Six Feet Under,* the death care industry underwent a phase of increased mergers and acquisitions. Service Corporation International (SCI), for one, became international as it expanded into the Canadian, Australian, and European markets. However, as this acquisitive period progressed, corporations incurred a great deal of debt.

At least partially related to the rise in corporate consolidation was the increased negative publicity funeral practitioners began receiving. Federal Trade Commission investigations of market monopolies and allegations of mishandled bodies led many of these companies to significantly restructure their businesses and scale back expansion plans, if not completely divest themselves of individual firms. One such casualty was the Loewen Group, which had once been the second largest funeral provider in North America and the largest in Canada. In 2002, Loewen declared bankruptcy. It eventually reemerged as Alderwoods. However, Alderwoods was subsequently purchased by SCI in 2006.

New Directions

When revenues are tethered to the supply of dead bodies, an essential resource, those revenues are limited by the number of available dead bodies at any given time. Production was, for most of the industry's history, centered on the dead body. The value added and thus the profits reaped from practices such as embalming, restoration, cosmeticizing, burial containers, burial real estate, and floral arrangements necessitated this limited essential resource of dead bodies. As with other industries where access to an essential resource is limited by natural barriers, diversification of output takes on added importance. On the other hand, when revenue is tied to the consumer's ability to assemble one's own product, the capacity for value-added production is limitless since there can be any number of goods, services, or experiences that can be created to that end. The death

care industry manufactures the raw material and tools for a product by providing facilities, meeting rooms, media equipment, burial containers, and crematoria. Workers within funeral firms assist the consumer in the assemblage and packaging of those raw materials in order to create the end product, which includes the funeral service, mementos, and keepsakes.

In the mid-1990s, the death care industry began to lose its dependency on material and durable goods and began to increasingly incorporate "cultural" goods. Thus, funeral products could be mediated through the symbolic representations of consumers through the creation of goods and services like videos, memory boards, highly participatory funerals, and celebrations. Where once the industry placed its emphasis on its ability to provide embalming and therapeutic expertise, increasing emphasis is now being placed on providing the consumer with the opportunity to symbolically represent, to themselves and others, the lives and social relations of the dead.

Tribute videos, ash scatterings, themed funeral services, assorted keepsakes, pet memorials, Internet memorials, webcasts, party planning, and jewelry are just a few of these cultural goods that the funeral industry has begun making a part of their merchandising repertoire. These goods are largely independent of the corporeal dead body, as a body does not need to be present in order for such goods to be sold. Instead the use of these cultural goods is dependent upon the ability of the consumer to coproduce a memorial for the deceased, products that can be purchased in multiple copies and formats or can involve more than one consumer at a time.

The death care industry has had to frame its goods as necessary enough to mobilize consumers and realize revenue streams. Simultaneously, it has had to address the needs of a progressively more ethnically, religiously, and ideologically diverse marketplace. The death care industry has had to present its goods as universal in need but individual in application. To accomplish this, the death care industry made customization of nearly all of its products and services available to customers. The base product (e.g., a casket) is readily identifiable to consumers, and yet, via various appliqués and accoutrements such as engraving, pillows, and shelves, the possible permutations of the end product are nearly endless. The death care industry began promoting its own personalization stance most heavily in the 1990s, and this trend continues to the present.

Finally, the continuing rise in the cremation rate in the United States (approximately one third of all cases) has had a significant impact on the death care industry. Cemeteries are increasingly providing not only burial services, but columbaria, or niches, and scattering gardens. Casket companies have diversified their product lines and now many offer urns, keepsake mementos, and other services. Historically, most of the revenue earned by funeral homes came from the sales of burial caskets. Many funeral homes have also adapted to rising cremation rates by emphasizing services and the creation of funerals as events.

Cultural Structures Affecting the Economics of Death Care

The economics of the death care industry is historically linked to broader cultural shifts, technological developments, and various economic trends. One such structure that impacts the means of production is consumer demand. Consumer demand varies depending on a number of factors, including the death rate, age demographics within a given market, religious attitudes (especially with regard to cremation), region of the country, and spatial distribution of the population that may have an effect on the degree to which a population is tied to a locale.

The competition for consumers has added weight, with so much at stake in anticipation of the baby boom customers. There are a number of dimensions along which marketing efforts in the death care industry take place. Funeral homes have traditionally relied on word-of-mouth references, aftercare programs in which a representative of the firm follows up with the bereaved, the inclusion of the firm's name and logo on calendars and on items like napkins or paper plates that may be used in a funeral reception, and advertisements in the obituary sections of newspapers and church bulletins. Sponsorships of area organizations, participation in charity events, and involvement in civic organizations have also served to promote funeral businesses. More firms are beginning to turn to radio spots and television ads for marketing purposes.

Branding is becoming increasingly important, especially among corporations that can leverage their abundant resources in combination with their diffuse geographical presence. Some companies, such as SCI, maintain a multifirm presence in a given market region by designating individual firms to represent different lines of brands (e.g., one firm is a low-cost provider, another emphasizes cremation services, and still another attends to the needs of a particular ethnic demographic). Stewart Enterprises uses its brand to promote its combination cemetery–funeral home firms. Some national brands have also created relationships with nondeath care–related companies like airlines or other service providers from whom loved ones might draw after someone has died.

Branding is also deployed with regard to iconic or highly recognized products. Some companies specialize in purchasing licensing rights to highly visible brands like Major League Baseball, Thomas Kinkade, and the American Kennel Club, among others. This allows manufacturers of products such as caskets, urns, and guest registries to brand those goods with, for example, the deceased's favorite athletic franchise.

Contemporary economic trends such as globalization and flexible specialization are also apparent in the death care industry. The withdrawal of highly restrictive trade barriers allows companies to establish branches outside national borders. There are multiple publicly traded companies that maintain an international presence. Batesville, the world's largest casket company, has, along with its manufacturing plants across the United States, two plants in Mexico. Batesville's distribution system is capable of providing rapid delivery of personalized caskets to funeral homes. This is also accomplished through the implementation of procedures that allow companies to create a basic template (e.g., a casket) at core manufacturing sites that can then be specialized (e.g., adding unique cornices) at various distribution centers. This system is increasingly used by companies that have several funeral homes in a single market. Fixed assets like storage facilities, equipment, hearses, and limousines can be shared among the various firms within a market.

Internet technologies have created the conditions for a surge in retail websites that sell goods like caskets and urns that were previously sold only at funeral homes. Retail differentiation has also affected "brick-and-mortar" stores. The consumer warehouse store Costco, for instance, now sells caskets at some of its branches. There are also specialty stores now present in most metro areas that sell flowers, urns, caskets, registries, and other goods straight to the consumer.

A final trend in the death care industry is related to rising social concerns over the environment. Formaldehyde is carcinogenic, and to curb its use many consumers are turning to ecofriendly burials that do not involve embalming fluids. Green cemeteries prohibit burials of bodies that have been injected with embalming chemicals and do not allow metal caskets. Biodegradable caskets and urns are rising in demand. Many consumers opt for cremation for environmental reasons, though it too carries the risk for air pollution. Some in the industry are looking to alternatives of body disposal such as freeze-drying (promession) and dissolving (resomation).

George Sanders

See also Cemeteries; Commodification of Death; Cremation; Funeral Home; Funerals

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Death Certificate

The death certificate is a document by which death is legally recognized. Permanently filed with

the state or district health department, the death certificate is a legal source of information that contributes to the needs of society that continues in function and structure after the individual is dead. The death certificate represents one of the officially reported documents surrounding an individual's life or, more significantly, death. This document includes a variety of information, the most important of which are the cause and circumstances of death, information that is used by public health analysts, government officials, and private business interests to estimate population growth, delineate health problems and assess health progress and program planning needs, and study the history of disease.

Like birth, marriage, and divorce, death is a social event that is celebrated through rituals and institutionalized through documentation. Death entails a legal process of registration that generates an important by-product, namely vital mortality statistics that provide the data essential to the construction of death rates, such as crude death rate, age-specific death rates, and the age-adjusted death rate. The creation of life tables to determine life expectancy among a stationary living population also is possible using accumulated death registry data. Such information allows for the study of sociodemographic correlates of multiple causes of death as well as more basic comparisons of death rates by age, sex, race, marital status, occupation, and level of education.

The death certificate provides information that is useful to population forecasting, adding to our knowledge of life expectancy, and provides information essential to those interested in genealogical study. As a historical document that recounts significant portions of an individual's life, it thus adds to the history of a community. One critical component of the certificate of death is that of medical certification. Other aspects of this document inform us of the overall ethnic and racial composition of a population, the levels of education, how people respond to the need to provide specimens for scientific study or the donation of organs, and the level of acceptance of nontraditional methods of body disposal such as cremation. Although less direct, an indication of movement patterns of the population also can be suggested from information recorded on this document. Finally, if certified by a medical examiner, information and testimony relating to this document can be used in criminal and civil courts of law.

Evolution of Death Registration

The term *statistics* is derived from the Latin phrase *ratio status* and the Italian equivalent *ragione di stato*. Initially employed in the study of practical politics, the concept has undergone transformation from its original 17th- and 18th-century meaning and application to understanding the political science of European nation-states. Influenced by the statistician Quetelet during the early 1800s, the numerical element of a two-part conceptualization of statistics later began to take root, and it is this numerical component that came to dominate definitions of the term as it is currently used to mean the numerical study of social groups.

Vital statistics represent important events and are recorded at the time of birth, marriage, divorce, and death. Parochial registration of baptisms and burials were recorded as early as 1538, and the initial numerical scientific study of death records, authored by John Gaunt in 1662, is based on these data. Gaunt's categories included causes of death—a recording of vital information as a part of the evolving system of registration, which was to have, in the words of Edwin Shneidman, "great social and medical significance."

The investigation of death by coroners originated with the Articles of Eyre in 1194 England. These articles called for the election of three knights and a clerk for each English county whose assigned task was to protect the financial interests of the Crown when the death of other than an Englishman occurred. By the late 1400s, English justices of the peace had assumed the coroner's fiscal duties and, by 1538, parish clergy were required to keep a record of christenings, marriages, and burials. This form of graves registration documented by English clergy marked the origin of death and burial records, though Henry VIII may actually have initiated the registration of deaths in 1532 when widespread panic and fear erupted over the plague.

The oldest systems of registration of vital statistics are found in Scandinavian countries beginning with Finland in 1628, Denmark in 1646, Norway in 1685, and Sweden in 1686. Throughout the course of the 17th and 18th centuries, improved

documentation of public records and registries made quantitative analysis of health-related problems possible, especially when civil registration of births and deaths was first introduced in England and Wales in 1836.

By 1836, concern about the concealment of homicide and grave robbing prompted passage of the Births and Deaths Registration Act, which required that a death certificate be issued prior to burial in England and throughout Europe. This concern was prompted by the 18th- and early 19th-century practice of body snatching to supply cadavers to English physicians for instruction and research. However, it was not until 1911 that data on the cause of death, undertaken in Sweden, established the process of officially recording each death.

Death Registration in the United States

European colonists brought the graves registration system to the North American continent. In 1632, the Virginia colony passed a law requiring a representative from every church and parish to present at court a register of christenings, marriages, and burials for the year. This practice continued until 1639 when a registration law passed for the colony of Massachusetts mandated that responsibility for registration be transferred from the church to government officials, who began the task of recording vital events—namely, marriage, birth, and death. In 1644, this registration law was made obligatory.

The separation of church and state required by the Constitution of the United States held implications for the registration process. This early interest in vital statistics was based on fear of epidemics and a belief that population size is the most important element of state power, especially its resources and military strength. As local and state governments developed an infrastructure to deal with 19th-century epidemics, responsibility for death registration increasingly shifted to urban health departments and boards of health. These agencies also developed epidemiological strategies that led to the collection of information pertaining to regions where infectious diseases were localized; thus the number of deaths caused by infectious disease could be enumerated. Maryland and Massachusetts adopted a statewide registration law in 1842, and by 1851, seven states had enacted similar laws. However, it was not until 1900 that a centralized system of death registration was established. By 1933, all states had been accepted as a registration area.

The earliest U.S. mortality statistics were based not on death certificates but on the information collected during the decennial census. From 1850 to 1900 the decennial remained the single source of official mortality statistics in the United States. Then, in 1900, mortality data were gathered and issued annually by the federal Bureau of the Census on the basis of death registration.

Until 1946, the U.S. Bureau of the Census collected and reported national registration information. In 1946, this function was assigned to the Public Health Service, an organization that created the National Office of Vital Statistics. In 1960, this office was merged with the National Health Survey program to form the National Center for Health Statistics, an organization that, in 1987, became a part of the National Centers for Disease Control, currently known as the National Center for Health Statistics.

Information Contained

The death certificate has three basic purposes: (1) It registers the fact that a person has died (the registration process); (2) it certifies an opinion regarding the cause, circumstances, and manner of death (the certification process); and (3) it provides information that may be used for postmortem statistical and epidemiological research purposes. The importance of accurate and complete information is underscored by the fact that such information is used by local, state, and national government agencies and private sector organizations to monitor morbidity and mortality for scientific study, planning and changing public health programming, and other health-related initiatives, as well as for legislative action and research funding.

Cause of death is one of the most important types of death information recorded; it is based on the application of the International Classification of Diseases (ICD), a three-digit whole number with one or more decimal points added.

In addition to recording information that may hold global consequences, in the United States the death certificate must include certain data such as information pertaining to the decedent, the names of parents, the disposition of the body,

circumstances of death, and contributing cause(s) of death. It is also required that this document be signed by a physician or, in the case of equivocal death, a medical examiner.

The underlying cause of death is yet another important part of the mortality statistics recorded on the death certificate. This information serves the needs of public health officials whose interests lie in determining the direct and indirect cause(s) of death (such as infectious diseases) and the underlying cause of death (involving chronic disease and illness).

Recording the Underlying Cause of Death

At the beginning of the 20th century, infective and parasitic diseases constituted the major causes of death in the world population. Documents show that pneumonia and influenza, tuberculosis, diarrhea and enteritis, and childhood diseases were the major causes of death in 1900. In the wake of the vast positive effects of the medical health revolution of the past century, chronic diseases have replaced infective and parasitic diseases as the most important public health problem.

The precise documentation of the immediate cause of death, the intervening cause of death, and the underlying cause of death holds many implications of a legal and public health nature. First, information gleaned from the death certificate is used to settle estates and to determine beneficiaries of insurance policies and pension funds. In the second instance, information based on death certificate data provides statistics that are used by health care professionals in making determinations of the patterns of disease, for developing prevention strategies, and to identify weaknesses or deficiencies in health care delivery policies.

Known as diagnostic coding, the immediate causes of death differ from mechanisms of death. The following definitions guide these efforts:

- *Immediate cause of death:* the condition or complication that immediately precedes the death
- *Intervening cause of death:* other conditions brought about by the underlying cause and contributing to the death
- *Underlying cause of death:* the disease or injury that initiated the events resulting in death, or the circumstances that caused the fatal injury

These important distinctions call attention to the need to produce accurate public health data documented by those tasked with certifying death.

Conclusion

The U.S. standard death certificate has long been used as a guide for states to follow. The most current revised U.S. Standard Certificate of Death, implemented on January 1, 2003, provides an opportunity to create additional information, such as date of injury and description of how injury-induced deaths occur, information pertaining to traffic fatalities, the effect of tobacco products in the cause of death, and whether female decedents were pregnant. These changes hold important implications for the future.

It is also certain that revision of the ICD will have a marked effect upon certifying the cause of death. With a different method and rules for grouping diseases and classifying the underlying cause of death, system change affects the numbers and the ability to engage in the comparison of disease and other causes of death over time.

Death certificates serve as the foundation for understanding the cause of death and guide decisions about the allocation of medical resources. With increasing competition for available health-related research dollars and social service activities, researchers and other interested analysts hold an interest in the accuracy of the certifiers' recordings. Recoding refinement will undoubtedly lead to changes in the ranking of the most important causes of death; it is this kind of information that serves well the needs of those in charge of research funding priorities.

Finally, death statistics are essential for assessing the social, psychological, and public health of our communities. Thus, appropriate mortality statistics are of crucial importance for the future quality of life and health of a nation.

Dennis L. Peck

See also Autoerotic Asphyxia; Causes of Death, Contemporary; Equivocal Death; Psychological Autopsy; Tobacco Use

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Death Education

Humans have grappled with the mystery of death since they realized their own mortality. This ultimate cognitive and emotional challenge to make meaning of the cessation of life and its aftermath for the deceased and those surviving has led to a rich history of education about death across all cultures and at all ages of the life span. Death education may be defined as the informal or formal teaching and learning about the many facets of dying, death, and loss. This entry considers the various forms that death education may take; the goals of death education; its history and place in contemporary society; the relationship of death education to culture, religion, and life span development; and current issues in death education and its potential for the future.

Format and Goals of Death Education

In its most common form, death education occurs informally whenever discussions about death arise. For the young child, it may appear as an event leads to the inevitable questions directed to parents—a teachable moment. It may also occur for married couples who, in completing an advanced directive, desire to avoid legal issues relating to the fate of an individual hospitalized in a vegetative state. In such cases, death educators may be parents, friends, religious leaders, books, movies, or any venue in which death- and dying-related information is conveyed.

Death education also is experienced on a more formal level, such as in a classroom environment where an instructor guides a group of learners in understanding the content areas of death, as well as to help them interpret their own values and experiences with death. Such formal forms of death education take on a variety of formats, from short continuing education workshops and modules embedded in a broader course to semester-long courses. In this instance formal death education classes are sometimes found in high schools but more commonly in university curricula, in nursing and medical colleges, in religious institutions, at conferences on death and dying, in webcasts and satellite conferences, or in worksite in-service programs.

Increased recognition of the importance of both types of death education is due to a number of factors that affect contemporary society. Medical technology has increased the length of life, but these advances confuse many as they try to understand the many implications of the prolongation of life. Globalization has enriched individuals' encounters with others with different traditions, including the rituals and rites of passage directed toward the end of life. And television, the Internet, and other forms of instant communication have made the transmission of information almost immediately accessible to anyone.

The goals of death education tie into personal, intellectual, and professional needs. On the personal level understanding dying and death aids in the clarification of personal values, leads to self-understanding, and helps one to set priorities in life. It is through the lens of mortality that people determine what matters to them the most, examine their religious teachings, and ponder the existence of an afterlife. Death education can also provide necessary understanding of the process of dying or instruction on how to speak to and help those who

are grieving. Most importantly, it can provide the tools that may be helpful when information or support, such as treatment, hospice, or funeral arrangement, needs to be accessed in the face of crisis.

On the scholarly and professional levels, death education can satisfy intellectual curiosity in an interdisciplinary framework. Social historians such as Philippe Ariès have been interested in tracing the changes in attitudes toward death that accompanied different historical periods, ranging from the notions of death as natural to death that is feared and denied. Death educators can teach their students about the changing nature of death concepts in children, ultimately leading to a more tolerant approach to children's reactions to the loss of a loved one. Most importantly, medical practitioners benefit from instruction about death and dying, which would lead to more compassionate treatment of those who are suffering from a life-threatening illness and greater awareness of the physical, emotional, and cognitive demands that death places on survivors. Death educators provide an environment wherein open discourse can be promoted for personal enrichment as well as for improved social policy and political decision making pertaining to the prevention of war, nuclear proliferation, and global warming.

History of Death Education

Death education can be traced back to the 1960s, when courses emerged, such as Robert Fulton's course on death at the University of Minnesota, Robert Kastenbaum's course at Wayne State University, and Dan Leviton's course at the University of Maryland, which was the first death and dying course in the public health field. From that humble start, death and dying courses proliferated to the point where virtually every college campus now offers a course in thanatology. Central to those early courses was the theme that quality of life would be enhanced by understanding death. The early death educators had limited published materials to draw upon, and perhaps that has contributed to what has become an interdisciplinary field. Knowledge about death was gleaned not only from the meager writings in psychology and sociology but also from the fields of literature, medicine, anthropology, and philosophy. Today there has been a virtual explosion of written material, including research published in journals such as *Omega: The Journal of Death and Dying, Death Studies,* and *Mortality.*

Two major teaching methodologies emerged from those early courses, and remain prevalent today. In the didactic method of death education, knowledge is typically delivered via lectures, reading, and discussion. The experiential form of death education emphasizes reflection and analysis of personal encounters with death, including emotional responses and processing of values and spiritual concerns. Evaluation of these teaching methodologies indicates that students learn content best via the didactic method, whereas the experiential method reduces death anxiety and leads to values clarification.

Issues in Death Education

Many of the goals of contemporary death education programs continue to mirror the first attempts at formal and informal education. And as the field of thanatology has evolved, so too has death education. In particular, the use of the computer for online education has opened up many new learning opportunities. On the informal level, information about virtually any aspect of death and dying may be accessed on the Internet. The challenge for the consumer is to identify reputable resources. On the formal level, many universities now offer their courses online. These courses may also incorporate the didactic and experiential elements by requiring that students participate in online discussions during which they share their opinions and personal encounters with death.

The Internet also helps promote global education and this too has influenced the perspectives that death educators take as they respond to an increasingly diverse student body and a cross-cultural context. Death educators recognize that cultural sensitivity is essential, especially among mental health and medical practitioners who work with the dying and bereaved. And while informal death education has always been a part of cultural narratives and teachings, the universal formal aspect of death education beyond the boundaries of the United States, the United Kingdom, Germany, Italy, and Japan is becoming better known.

A standard module in death education classes considers the development of death concepts, grief

in childhood, and issues facing the bereaved at different points in the life span. It is perhaps ironic that little formal work exists for children or people in the later stages of life. Death education in middle and high school classes is still relatively rare and often is controversial. For adolescents and young adults, death education most frequently occurs within the context of tragic events such as death from suicide, accidents, or homicide. For the middle-aged and elderly, life experiences are the most frequent death educator, although many turn to books and community events to inform them of death-related issues. Because of the potential for disseminating inaccurate information through the news and entertainment media, a current and future challenge for death educators is to provide educational programs that respond to the needs of all age levels and to more effectively utilize the media to disseminate accurate information and resources.

The first death education course of study consisted of survey classes in undergraduate liberal arts programs. Soon, more sophisticated offerings entered into professional nursing, medicine, social work, and clinical psychology programs. As end-of-life issues become better known and commonly shared, more workshops and other opportunities for continuing education have emerged, and yet postgraduate educational opportunities remain rare. There are graduate-level programs in thanatology, and death educators can become certified through professional organizations, but in both instances standards are not uniform.

Following current trends in pedagogy, death educators have incorporated methods of student engagement in the classroom, ranging from the use of drama—such as the play of a woman dying of ovarian cancer, by Margaret Edson, titled *Wit,* used in professional, undergraduate, and graduate education—to internship and service learning projects wherein students work in the field in a voluntary capacity and then bring their experiences back into the classroom.

Similar to other fields of inquiry, thanatology has increasingly integrated research and practice, through a process of "evidence-based practice." The idea is that intervention works best when it is informed by research findings, and research is more relevant when researchers are aware of the pressing concerns of clinicians. So too has this movement affected education, where the scholarship of teaching and learning has offered ways of researching educational methodologies to determine best practices for teaching and learning. Given its unique charge, death education currently is benefiting from this approach, as more scholars seek the most effective way of teaching about, and advocating on behalf of, end-of-life issues. The commitment toward the educational enterprise, formal and informal, at all levels of the life span, is evident in the work of death educators. It is their belief that in educating about death and dying, they truly are promoting an enhanced quality of life, both at the individual level and for the greater good of humanity.

Illene C. Noppe

See also Ariès's Social History of Death; Death Anxiety; Death Awareness Movement; Death Education; Defining and Conceptualizing Death; End-of-Life Decision Making; Thanatology

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Death in the Future

A discussion of death in the future can include topics relating to predictions about demographic

shifts in mortality, transitioning grieving, and burial practices. While all these issues are important, changes in the social characteristics and reactions to death revolve around more fundamental questions about the ontological nature of death. Examining the cultural understanding of death can help reveal the way death will look in the future. It is suggested here that as medical technology advances, biological death will wane in significance while sociocultural considerations will become increasingly important.

In contrast to the past, when war and acute injury and disease were leading causes of death, the present epoch is characterized by chronic illness deaths. That is, death today is linked not so much to singular moments but to the cumulative effects of ongoing health behaviors. As biomedicine continues to detect, intervene, and manage chronic illness, more people will continue to live longer. But death in this era of unprecedented life expectancy may at times be prolonging life of significantly diminished quality. In the future, health care advances perhaps will deliver a more successful aging process, with less prolonged morbidity. Death also may be seen as less tragic when individuals are given a chance at a full biography with relatively full functional ability.

Biomedical and social-behavioral fields differ in focus, but the epidemiological trinity of agent, host, and environment can accommodate interdisciplinary perspectives. Instead of viewing this triad strictly in terms of physical components, broader social definitions, including behavior and lifestyle, various social systems, and social psychological components of the environment will be necessary additions to future inquiry as society continues to struggle and adjust in the era of chronic illness. With extended periods of end-of-life dysfunction, this will include identifying typical physical health dangers to living independently, as well as social factors such as bereavement, isolation, prolonged grieving, caregiving, and widowhood. These critical social-behavioral factors signify potential displacement from social roles and extensive dependence on others prior to death.

Additionally, the variety of social practices surrounding death are not static features of human history but change in relation to structural conditions. For example, increasing scarcity of space, particularly in urban centers, gives impetus for growing rates of cremation. As cremated remains require significantly less space than do bodies, cremation should continue to grow in popularity in relative proportion to increasing expense of scarce burial space. In general, death's effects on similar social practices likely will continue to respond to constraining material conditions of society.

But the most central consideration about death in the future concerns the definition and meaning of death itself. Like its surrounding practices and institutions, cultural meanings of death vary across time and context. Religion and medicine have different visions of death and these intersect with human history, the former being clearly dominant until comparatively recent successes gave medical science unprecedented significance. Moreover, religion and medicine hold a contentious relationship, as scientific advances challenge religious prescriptions; this is exemplified in the case of euthanasia. Finally, the social meaning of death changes as medicine continually adjusts its death criteria. The sections that follow describe how advances in medicine will establish new understandings of death and alter what it means to be human.

Death and Self-Concept

Criteria for the declaration of death have shifted as medical diagnostic capacities improve. Continual revision of death indicators has produced collateral shifts in the concept of death and what it means to be human. Until recently, death was delineated by the cessation of a beating heart. This was particularly problematic in the past when death diagnoses were vulnerable to error. Legend is that people were buried with a bell to be used in those instances when the "deceased" woke up. The saying "saved by the bell" is attributed to this past practice. Even if the factual matter here is mere folklore, the clear indication is that in the past, diagnosing death was a less-than-surefooted activity.

As advances in technology allowed medical practitioners to improve their diagnostic abilities, the cessation of brain activity was accepted as a better indicator of death. Moreover, the ability to mechanically motivate heart rhythm and breathing allowed many bodies to be kept alive indefinitely. With these advances, death is increasingly related to the end of one's consciousness and less related

to the physical functions of the body. As culture still is in the midst of this transition, conceptualizations of death still vary widely and currently are meted out on an individual basis in the form of advanced directives, wherein individuals decide whether mechanically sustained organ function acceptably constitutes life or whether conscious brain activity is required. Such decisions imply the controversial debate over whether life has some inherent value or is only valuable as a conduit of experience. Medicine's almost unlimited capacity to sustain biological life has resonated as an increasing cultural preference to identify life as fundamentally about consciousness rather than organ function. Even as conservative religious groups contest this transformation in the life/death concept, medical advance likely will continue to propel the historical trajectory toward life-as-consciousness.

The End of Death

Developments in medicine have challenged past understandings of death, and the rapid pace of scientific advancement may culminate in the end of death, at least in its current form. Research beginning in the 1960s put human brain transplants within the foreseeable reach of medical science. Whereas for the lay public this largely remains the stuff of science fiction, scientists have successfully transplanted the brain of one dog to the neck vessels of another while maintaining the biological viability of the animal. As medicine continues to develop, there is reason to suspect that these could render biological death a historical artifact with interesting sociological possibilities. Although this future possibility may be difficult to foresee, the history of medicine is replete with many accomplishments that were thought impossible. It was only 200 years ago, for example, that Ephraim McDowell shattered the pervasive belief that surgically opening the abdominal cavity meant inevitable death for the patient.

The prospect of brain transplants predicts transformations in cultural notions of life and death. Whether or not any such procedure materializes, even the discussion of brain transplants implies future reconsideration of what it means to be human. Questions immediately emerge about whether selfhood belongs to the person of the brain, the person of the body, or some new person altogether. Cultural inclination is that the person of the brain has claim to selfhood insofar as the brain is thought to store the contents of the self, including the biography, experiences, values, and will. But this conclusion implies transitioning meanings of death.

Current debate about euthanasia centers on opposed claims about the inherent or utilitarian value of life. Right-to-life activists suggest that life has sanctity regardless of consciousness; that is, the value of life is unaltered by one's ability to experience and interact with one's environment, as in the case of those in persistent vegetative states. Right-to-die positions suggest the value of life turns on consciousness; life's value emanates from experience and interaction. If it can be assumed that the selfhood of the brain-transplant patient would be given to the person of the brain, it is easy to see how the prospect of brain transplants supports the idea that consciousness is the definitive quality of human life. This would continue or perhaps culminate in the trajectory of cultural conceptions of humanness, where the brain increasingly is considered the central human organ. While lingering notions about the sanctity of life are bolstered by the fact that the body and brain remain paired, disaggregating the body and brain likely will cement consciousness as synonymous with human life. Of course, cases such as Nancy Beth Cruzan, Karen Ann Quinlan, and Terri Schiavo suggest this will be contested in the courts, but the large-scale trajectory of the life/death concept toward consciousness suggests these politicized moments are small resistances to a sweeping cultural tide.

A concept of death that is wholly defined by consciousness likely will place death more fully within the realm of culture. Those things associated with consciousness, such as experience, sentience, values, will, and intention, all interface with and are dependent on the external, social environment. If biology increasingly is disassociated with death and consciousness continues to assume a more central role, it may be said that life and death will become largely understood as social phenomena. In other words, if consciousness is synonymous with life and by definition entails social interactions, then death, as the cessation of consciousness, will come to mean the cessation of social functions.

New Approaches for a New Concept of Death

The social and behavioral science of death currently relies heavily on the meanings and impacts of biological death. But a concept of death that is fully related to consciousness propagates it more fully as a social matter. The social-behavioral sciences therefore ought to experience and embrace a new role in studying death and fleshing out the widening parameters of death's increasingly social features. This is not to say that biology and medicine will not have equally, if not increasingly, important roles to play in managing life and illness, but the cultural implications of death that are essentially related to consciousness suggest expanding roles for social science disciplines. It should be clear, however, that this reflects a transition in the cultural definition and meaning of death, not denigration of the importance of particular scientific fields.

In a future era of death that is quintessentially social, society will be challenged to find new interpretations of death that are not inherently predicated by the biomedical paradigm. One possibility for the meaning of social death is that of sociopersonal change. Something about a person comes to an end and will never be lived by that individual in that way again. When that happens, part of a person dies; but with a fully social notion of death-as-change, the person can mourn and then be reborn as a changed person. As it is radically distant from current cultural conceptions of death, this may seem like an "oddball" explanation. However, an increasingly social concept of death could make currently radical interpretations commonplace.

Some classic social science concepts may be recast in light of a new social notion of death. For example, the stages of the life course are punctuated by role transitions, as in the transition from child to parent. Significant role transitions represent shifting modes of consciousness, an uprooting and reconstituting of one's social place. Child-consciousness and parent-consciousness are different, not only because of the cumulative experience of the older parent but also because one's social place is acutely altered when one assumes that role. Such transitions often can be a rather sharp break from one's past role. "In a past life . . ." is a popular figure of speech that captures these types of role transitions, but future cultural conceptions of death-as-change may transform such sayings into more literal forms. That is, death might be culturally understood as what happens when one exits a past life role and is reborn into a new one.

The trajectory of the concept of death-toward-consciousness, combined with future prospects of medicine, suggests that in coming decades culture will experience radical transformations in understandings of what death means. These transformations will usher in new roles for science and medicine, including avenues of study for social and behavioral science that are not wholly encapsulated by the social fallout or social construction of biological death, but speak to the very notion of death itself.

Jeffrey Michael Clair and
Jason Adam Wasserman

See also Ariès's Social History of Death; Brain Death; Causes of Death, Contemporary; Death, Clinical Perspectives; Death, Sociological Perspectives; Defining and Conceptualizing Death; Euthanasia; Medicalization of Death and Dying

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Death Mask

A death mask is usually a wax or plaster cast of the face, created once a person has died. Although somewhat uncommon in the 21st century, in the past they were produced for a variety of reasons, including as a homage to the deceased, for use in rituals, to be used as effigies, to create a record of the deceased's facial appearance, or for scientific and medical research. Famous people who had a death mask include Benjamin Franklin, Oliver Cromwell, Isaac Newton, Ludwig von Beethoven, Friedrich Nietzsche, Ned Kelly, Joseph Stalin, Mary Queen of Scots, and Frédéric Chopin.

Typically, death masks are created soon after the individual has died and before gravity has begun to distort the facial features. Because the mask comes directly from the face of the deceased, it is an extremely accurate and precise representation of the person. This also means, however, that the cause and pain of death can also be seen in the masks; for example, it is often possible to tell whether the deceased had suffered a stroke due to the drooping of one side of the face.

The process of making a death mask is relatively straightforward. First, the facial features may be manipulated to present a particular expression, before lubricant is spread over the face and neck and a casting substance is applied to the face. Once the cast has set, the lubricant allows it to be removed in one piece. The cast can then be left in this state or embellished with paint or jewelry. Sometimes masks have been made from iron or other metals, such as bronze.

Death masks have a long history throughout the world and have been found in many early civilizations, including the Incas and Roman Empire. Many historians and archaeologists have cited their earliest known origins to be in ancient Egypt. Evidence found in Egypt suggests that between the Middle Kingdom (approximately 2000 B.C.E.) and 1 B.C.E., death masks were sculpted as a likeness of the face of the deceased and placed on top of their mummified remains before interment. In accordance with beliefs about life after death and the fate of the soul, it was believed that these masks would provide a face for the dead in the afterlife and enable the returning soul to recognize his or her own body. Sometimes a more lavish sculpture of the deceased's face would also be left in their tomb. These masks would be adorned with gold and jewels depending on the status of the deceased individual. The most famous of these is the gold mask of King Tutankhamen.

Death masks have been used in funeral rituals throughout the world. Both in the past and today, for some African, Oceanic, and Native American tribes, death masks—made either directly from the face of the deceased or as a likeness—form an important part of the funerary rites that surround the dead person. They are often used to evoke the image of death at these ceremonies or to assist the deceased's soul in its transition to the next life. These masks may also be used in other tribal ceremonies to remember and honor the dead. In this way, they can act as symbolic markers between the past and the present.

Between the 14th and 18th centuries in Europe, death masks were commonly used by sculptors to recreate a lifelike face on statues or busts of the deceased. During this time, death masks were also used as effigies of notable people, particularly of royalty and statesmen, such as King Henry VII of England and Vice Admiral Horatio Nelson.

Throughout the 18th century, and into the 19th and 20th centuries, death masks were used extensively by those interested in health and disease. As a result, death masks were regularly used by medical practitioners and scientists in their search for the cause and affect of what was considered to be "unhealthy behavior." In particular, executed criminals' death masks were studied for evidence of psychopathic tendencies. Masks were also used in the study of phrenology, in which the head is divided into 35 sections in order to study an individual's motivations, strengths, and weaknesses.

However, these types of studies of the face and head fell out of favor in the 20th century with the development of medical and psychological knowledge about behavior and the advancement of technical intervention in diagnosing disease. This led to a move away from bodily determination of behavioral tendencies, toward a more psychosocial understanding of human behavior. At the same time, in terms of recording the face of the deceased and in line with the growth of photography, death masks were replaced by postmortem photography, which in turn has been superseded by computer technology and forensic facial reconstruction.

Today, death masks are rarely made and, as a result, those that survive in collections and exhibitions have become something of a source of fascination and intrigue. In recent years, death masks have also been used to make political statements, such as in the case of sculptor Nick Reynolds, who created a death mask of an executed prisoner in 2007. The intention of this mask was to campaign against the death penalty.

Kate Woodthorpe

See also Depictions of Death in Art Form; Depictions of Death in Sculpture and Architecture; Egyptian Perceptions of Death in Antiquity; Personifications of Death; Photography of the Dead

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Death Notification Process

Death is experienced not only by the deceased but also by the survivors of the deceased, who are profoundly affected by the loss of their loved one. Recognizing the profundity of the loss of a loved one, societies and the organizations therein construct guidelines—both formally within organizations and culturally—for delivering such grave news to the next of kin. For the survivors, the death notification is a ritual that initiates the final stage of the life course for a loved one and the beginning of the grief and bereavement process. This entry examines the history of death notification in the West and some of the characteristics of the death notification process in the United States, focusing on some of the common elements of its delivery for private audiences (i.e., the next of kin) and public audiences via the mass media. As no uniform death notification process exists, there is much organizational variation in the death notification process within the United States as well as cultural variation of the process outside the United States.

History of the Death Notification Process in Western Society

In the 18th and 19th centuries, prior to formal organizations taking over the death ritual, death occurred in the home and often in the accompaniment of close family and friends. The responsibility for notifying others of the death of the individual fell on the family members. In small communities, the news of the passing of a community member was spread informally between members of the community. In Europe, death was often announced with the tolling of the bells. In other communities, a funeral notice was often posted on the window of a building, allowing community members to see who had passed away recently. In other areas, notification was more symbolic, such as when individuals would wear a black badge around their arm to indicate the passing of a loved one.

In the 20th century, with the advent of new communications technology such as the radio and the telephone, death notification could now be related to a mass group of individuals relatively quickly. It was in the early 20th century that formal organizations such as funeral homes and hospitals began to take on death rituals. These organizations utilized these new forms of communication to alert people of the passing of the individual. Today, although death notification is often done in person, alerting the public to the death of a person often occurs through some communication technology, such as the telephone or the television.

Elements of the Death Notification

Several researchers, medical practitioners, and service professionals have identified key elements in the process of death notification. Some of the highly consensual aspects of the process are to make sure, first, that the family receiving the notification has accurate and adequate information about the cause of the death as well as information about the funeral procedures; second, that at least

two people present the notification; and third, that the language is straightforward. For example, the assigned emissary (i.e., the person designated to deliver the notification) should use the word *death* or *killed* when explaining the events to the family and should avoid minimizing the loss or assigning blame. It is important to keep the information simple and to the point. Emissaries also provide empathy to the family during their trying time. Importantly, the grieving family should have access to view the body. Finally, the death notification process is not a singular event. Emissaries should follow up so that the family is aware of any additional beneficial services.

Delivering the death notification must take into account the way the person died. There are common elements of death notification depending upon whether the person died unexpectedly or whether the death was expected. Both cases require that the person delivering the notification be skilled in a certain amount of emotional labor. Natural and expected death requires the notifying person to display a certain amount of empathy toward the grieving parties. For expected deaths, the notifying person is a resource for the family as they begin the funeral process. It is particularly important that the person notifying be knowledgeable about the death process. In many cases, the notifying person performs a more practical role for the grieving family than if the death is unexpected.

For unexpected deaths, the notifying person must manage the various types of emotions emitted by the grieving family. The person conducting the death notification must deliver the notification in a professional manner (some key methods are highlighted later in the entry), but the person must also deal with the range of emotions possible during such an event. The notifying person should allow the family to display their emotions, while at the same time moving the family through the beginning of the death process.

Public and Private Death Notification

Formally, upon initial discovery of a person's death, the next of kin and the general public are generally notified of the death. Under normal circumstances, death notification begins as a private ritual in which a representative from the legal, health, or medical organization responsible for the discovery or handling of the deceased delivers information to the next of kin. Notifying other immediate family and friends then becomes the responsibility of those initially notified. The purpose of the notification is to provide a firsthand, respectful, and official announcement and confirmation of the death to those closest to the deceased so that they may begin the grieving process.

Although the next of kin are responsible for notifying other formal organizations of the death (e.g., banks, place of employment, insurance company), they often delegate responsibility of notifying the general public to certain organizations (e.g., funeral homes, local, regional, or even national print and broadcast media). By so doing, the delivery and content of death notifications for the public take on different characteristics than the private notification. The initial private notification generally involves dialogue between the notifier and the notified and includes a detailed narrative regarding specific events pertaining to, and information (both good and bad) about, the actual death, which the next of kin, then, can censor for the public notification. Public notifications, on the other hand, are commonly much shorter, impersonal, delivered through mass media, and focus exclusively on positive aspects of the deceased.

Obituary and the Mass Media

The most common mass medium for public notification is the obituary. Local newspapers, news websites, or funeral home websites often list such announcements. Not only does the obituary involve announcing a death and funeral arrangements, it also serves to crystallize positive aspects of the person, such as hobbies, occupations, and professional and personal accomplishments. In most cases, along with the delivery of the death notification, the composition of the obituary, too, is delegated to appropriate organizations (e.g., the funeral home or print media). Although some individuals choose to write their own obituaries before they die, the construction of the obituary is generally a collaborative effort between the next of kin and representatives of the appropriated organization. In both cases, the resulting obituary is highly positive in tone, one that highlights the person's positive qualities while excluding negative characteristics.

The mass media often engage in two types of death notifications. First, in the case of some dramatic and tragic event, the mass media report the newsworthy facts surrounding the event. For example, on August 3, 2008, CNN ran a story of an avalanche that claimed the lives of 11 people as they were descending K-2 Mountain on the India–Pakistan border. The story included details about how the avalanche occurred; the number of, and information about, the known casualties; and recovery operations under way. However, different constraints bind the mass media on how they notify the public of a death. Usually, as a courtesy to the person's family, the mass media will not release the name of the deceased until the immediate family has been notified.

Second, the mass media deliver pseudo-obituaries for famous persons. They announce the death of the deceased public figures while noting the particulars of their fame. For example, when a public figure dies, the mass media agencies present a brief recounting of the notable aspects—both good and bad—of their public lives. In this case, the public notification of death by the mass media is intended to announce the passing of the public figure and crystallize the collective image of the person.

Organizational Variation of Death Notification

Although there are common elements in the structure and delivery of private death notifications, the formal protocol for notifying the next of kin varies among formal organizations. Within hospitals, policy constraints affect how medical practitioners deliver the notification. The Health Insurance Portability and Accountability Act (HIPAA) mandates specific procedures for the delivery of the death notification by medical practitioners. For example, medical practitioners must protect the privacy and security of an individual's records, while still providing necessary access information to legally certified public health and safety personal and funeral coordinators. For example, if the death raises concern for public health, medical practitioners must release the patient's records to the public health organization requesting the material, such as the Centers for Disease Control and Prevention. Second, HIPAA states that the death notification must be done in person by a doctor and should reveal only general information about the person's medical condition over the phone. Finally, HIPAA mandates that the delivery of the death notification can occur only by a licensed medical practitioner (doctor or registered nurse in some cases).

Trained law enforcement officers handle unexpected deaths such as those resulting from violence or traffic accidents. In the notification, police are often bound by evidentiary standards as to how much they can reveal to the next of kin about the death. For example, if the death resulted from homicide, certain details may be withheld in order to find and arrest a suspect. Police departments have varying notification procedures. Although the formal death notification for law enforcement officers is usually departmentally specific, most departments follow specific guidelines associated with the disclosure of information regarding the death.

Unlike law enforcement, although each branch of the U.S. military handles its own death notification, all branches of the U.S. military follow a similar, highly rigid death notification protocol. The U.S. Army, for example, assigns the duties of organizing and conducting the death notification to the Casualty Notification Officer (CNO). CNOs must follow a strict protocol for contacting the next of kin as well as a specific script for delivering the news of the death. The notification is delivered face-to-face between 6:00 a.m. and 10:00 p.m. by two soldiers—one officer of equal or higher rank than the deceased—and, when possible, a chaplain, all trained in death notification and grief and bereavement. Prior to notifying the next of kin of the death, they must (a) identify themselves by name, rank, unit, and duty station and military branch; (b) state that they are representatives of the Secretary of the Army; and (c) officially confirm that they are speaking to the next of kin by verifying her or his name, address, and phone number.

Cultural Variation of Death Notification

The death notification process varies within and among societies. This variation is partially organizational; however, every organization within a society is inherently embedded and profoundly shaped by the unique beliefs, values, and rituals of the broader collective culture. Therefore, the death notification process in the United States is unrepresentative of the notification process in other

cultures and societies. For example, Chinese Daoists notify the gods, along with notifying family and friends, by burning farewell messages during a postdeath ritual; they also participate in loud wailing to let immediate neighbors know of the death. Similarly, on the peninsula of Anatolia, Turkey, the survivors of the dead person cry loudly, at which time neighbors congregate in the deceased's home to share in the grief of the survivor(s). In larger towns, hodja (respected leaders) announce the death by calling the community together for a funeral service. In addition, messengers are sent door to door to announce the death of a community member. In the Republic of Guyana, death announcements are displayed on a daily broadcast, titled "Death Announcement," which is a popular television show among the Guyanese. Ultimately, regardless of the cultural or organizational variations, the death notification process represents a significant ritual in the death and dying process for the survivors of the deceased.

Jason Milne and Steven J. Seiler

See also Condolences; Coping With the Loss of Loved Ones; Grief, Types of; Obituaries, Death Notices, and Necrology

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Death-Related Crime

Death-related crime includes behavior that results in the death of others, including the crimes of murder and manslaughter; behavior that victimizes the dead, through desecration of the dead bodies; and behavior that uses the dead to victimize the living. This entry provides an overview of these crimes and also discusses crimes involving the dead that are motivated by a search for economic gain.

Behavior That Results in the Death of Others

Murder and Homicide

The terms *homicide* and *murder* both refer to the killing of one human being by another. However, murder is a narrower concept and applies only to cases in which a killing is defined as criminal. The term *homicide* refers not only to murder but also to other acts of killing that are deemed justifiable, primarily actions that involve self-defense.

Although different jurisdictions have different definitions of criminal homicide, most states distinguish between *first-degree* and *second-degree murder*. First-degree murder requires the presence of both premeditation—that is, planning the killing ahead of time—and malice aforethought, or the specific intent to kill the victim. In addition, courts may allow prosecution of an offender for first-degree murder under the felony murder rule, if the murder is committed in the course of another felony crime. In such a case, the offender can be charged with murder even if the killing is accidental or unintentional. The general approach of the courts is that such charges should be brought only when the felony the offender intended to commit was dangerous; however, there are significant differences in how this concept is applied. Second-degree murder, in

contrast, involves cases in which the offender intended to kill another person but did not plan the killing ahead of time.

An unsuccessful effort to kill someone is known as *attempted murder.* Planning by two or more individuals to kill someone is known as *conspiracy to commit murder.*

Variations of homicide include *infanticide* and *neonaticide*. The former refers to the killing of a child under the age of 1 year. An example of infanticide is a babysitter caring for a 10-month-old infant, who violently shakes the child when it will not stop crying, resulting in the death of the infant. Neonaticide is the killing of a newborn on the day of its birth. An illustration of this variety of murder is an unmarried pregnant teenager who has an unassisted birth and then smothers the infant and throws the body in the trash to disguise the fact of her illegitimate baby.

Manslaughter

The crime of manslaughter is a lesser charge than homicide and is distinguished from murder by the offender's state of mind. In the case of *voluntary manslaughter*, the offender intends to cause serious injury or death, but the offender may have formed this intention and carried out the act in the heat of passion; for example, the offender may have been uncontrollably enraged by discovering his or her spouse with a lover, or by seeing someone attacking his or her child. Courts also distinguish between second-degree murder and voluntary manslaughter in part by considering not only whether the action was done in the "heat of passion" but also whether if was provoked by something that might have caused a reasonable person to temporarily lose self-control.

In the case of *involuntary manslaughter,* the action is viewed as the result of negligence or recklessness rather than the intent to kill. The offender may have recklessly ignored the dangers of his or her actions—for example, leaving a child alone in a parked car on a hot day. A common form of involuntary manslaughter is vehicular manslaughter, in which a driver causes a fatal accident while driving under the influence of alcohol or drugs. Another form of involuntary manslaughter occurs when someone's action in committing a misdemeanor results in another person's death; for example, a person may run a red light (a misdemeanor) and by doing so, cause the death of a pedestrian.

Serial Murders

Serial killers are those who kill multiple people over a period of time, usually using similar means and/or choosing similar victims. Jack the Ripper in England, who murdered more than five women and then mutilated their bodies, in the autumn of 1888, committed serial homicide. Another example is the Boston Strangler, who murdered 13 women over a period of 2 years in the United States. Yet another serial murderer in the United States was Jeffrey Dahmer. Dahmer compounded the heinousness of his crimes by eating parts of the bodies of some of his victims. Such multiple murders often reflect mental pathology, or a perverted sense of excitement.

Mass Murders

The term *mass murders* refers to the killing of multiple individuals in the same place at one time. There are three categories of mass murderers. These include individuals who kill a number of, if not all of, their family members. The killers frequently take their own lives or provoke the police into killing them. A second category of mass murderers are those who have a fascination with firearms and seek revenge on some group of people who they believe have insulted, belittled, or harmed them. Examples would be the mass school murders on April 20, 1999, at Columbine High School, in Colorado in the United States, where two students shot and killed 12 other students and 1 teacher before committing suicide. A similar mass murder occurred at Virginia Tech University in August 2006. A student killed 32 students and faculty members and then killed himself. The offenders frequently have planned the killings well in advance. Such murders as these two crimes are often referred to as *spree murders* or *massacres*. Yet a third type of mass murder is the situation in which an individual, or group of individuals, seeks to kill a large number of persons using a bomb or some other type of weapon, capable of killing multiple victims. Such a case was that of Timothy McVeigh, who bombed the Alfred P. Murrah Federal Building in Oklahoma City on April 19, 1995. This mass murder claimed the lives of 168 victims.

Another example of *mass homicide* is the attack on the twin towers of the World Trade Center in New York in the United States on September 11, 2001, which resulted in the death of 2,973 identified victims and 19 hijackers. Mass murders such as these are acts of terrorism motivated by political or religious ideology.

Wrongful Death

Death sometimes occurs in the course of common activities as a result of a mistake, the use of an inappropriate procedure, or an accident. In the medical world, if a patient dies as a result of surgery, because of medical error, or lack of appropriate expertise, the death could be classified as *wrongful death*. Recovery for wrongful death includes two types of civil claims. One is a claim for recovery based on noneconomic factors such as the pain, suffering, fear, and loss of the enjoyment of life of the decedent; the other claim is for recovery of economic losses of the estate of the deceased. Other examples of wrongful death are accidental death caused by defective machinery owned by the construction company, or an employer not providing appropriate protective gear for workers handling toxic material.

Violations of Norms Concerning Treatment of the Dead

Almost all societies have elaborate prescriptive and proscriptive normative systems and taboos regarding the dead. Offenses against the dead are considered to be reprehensible. In spite of the emotional intensity of taboos and norms pertaining to the dead, violations are not infrequent in many societies.

Offenses involving the dead can be separated into two major categories or divisions, in terms of the pattern of victimization. In one such pattern the deceased individual is directly the victim of the offense, with the body itself often being the object of the criminal act. In the second pattern, the dead are used in a strategy to victimize the living.

Desecration of the Dead

The desecration of the dead is almost universally condemned as morally depraved and reprehensible behavior. In the United States, as in most other societies, legal statutes protect the dead and their place of final rest, thus acknowledging the right of the dead to peaceful and undisturbed repose.

The taking of body parts as battle trophies has many historical precedents around the world. During the invasion of Korea by the Japanese in 1597, the noses of 20,000 Korean soldiers were cut off by Japanese warriors. The taking of scalps or other body parts as war trophies was part of the culture of indigenous peoples in North and South America. In medieval Japan, the Samurai warriors routinely took the heads of the enemies they killed in battles. During the Spanish Civil War, General Franco's Moorish troops often castrated the corpses of the enemy soldiers they killed. During the Italo-Ethiopian War of 1935–1936 Italian soldiers were sometimes tortured and castrated by Ethiopian troops. The Ethiopian soldiers, in turn, were sometimes killed and castrated by Galla tribesmen. In the siege of Khartoum in the Sudan in 1884–1885, General Charles "Chinese" Gordon, the commander of the Egyptian and British forces, was killed and decapitated by troops of the Mahdi. His head was impaled on a pike as a trophy. Such practices, while often viewed as socially barbaric and in violation of military law, have nevertheless occurred in some more recent combat situations. In World War II, some U.S. Marines collected the teeth and ears of dead Japanese soldiers after a battle. During the Vietnam War, some soldiers would cut off the ears of dead Viet Cong soldiers, string them into a necklace, and hang them on the radio aerial of their vehicles. The Geneva Conventions require the demonstration of respect for the dead, and Rule 113 states specifically that parties to armed conflict "must take all possible measures to prevent the dead from being despoiled" and prohibits the mutilation of bodies.

Some crimes against the dead have pathological or compulsive motivations. Included here are acts such as mutilating a body or failing to bury or otherwise properly dispose of a body. Some crimes that victimize the dead are motivated by the desire to engage in malicious mischief. Vandalizing tombs and cemeteries and desecrating dead bodies are examples of such crimes.

Using the Dead to Victimize the Living

Using the dead to victimize the living may also be the result of mental pathology or compulsion. An

individual's hatred of a person or family may be so intense or so pathological that he or she may seek to harm the survivors by committing offenses against the deceased family member, by desecrating the body of the deceased, or by vandalizing the grave.

The vandalism of certain types of cemeteries may be motivated by an intense, pathological desire to inflict insult, harm, or psychological injury on the living—a racial, ethnic, or religious group, for example. An illustration might be spray-painting neon orange swastikas, epithets, messages about killing Jews, and other anti-Semitic graffiti on the gravestones of a Jewish cemetery. Monuments and memorials to the dead may also be damaged or harmed as a means of striking out at some group or category of people whom the offender associates with a person to whom the monuments and or memorials are dedicated.

In some instances, people find humor and amusement through death and may culminate their distorted sense of humor by victimizing families of the dead. It is not uncommon for families who have had a member die to experience crank telephone calls and practical jokes. Callers may ask for the deceased, claim they are the deceased, or say they are calling for the deceased. They may vandalize the home of the survivors, or even the recently closed grave, and then notify the family of the acts. They may place orders at fast-food restaurants in the name of the deceased and have them sent to the home of the family. The family is often vulnerable at this time, and the offender may use the occasion of an individual's death to entertain himself or herself by annoying the family with such malicious mischief.

Economically Motivated Crimes

The goal of profit and economic advantage often motivates death-related crimes. For examples, individuals may steal bodies or body parts to sell, they may steal objects such as historic tombstones to sell to collectors, or they may steal bronze grave flower urns to sell to scrap metal dealers.

Grave Robbing

Graves and tombs, especially from historic burial sites, have been robbed by collectors and amateur archeologists seeking souvenirs, such as jewelry, military accoutrements, or other artifacts, that had been buried with the dead. Indian mounds and burial sites are often rich lodes of relics, such as arrowheads, pottery, beads, and even skulls or skeletons. Collectors defiling Indian burial sites for souvenirs on federal lands may be subject to a $20,000 fine and a 2-year prison sentence for the first offense, if arrested, tried, and convicted. They would receive $100,000 fine and 5 years in jail for subsequent convictions.

The dead can also be used as an instrument for the commission of criminal acts. The dead can provide leverage to extort and manipulate the living. In doing so, the living are victimized. Examples of such criminal acts include using dead bodies as hostages in an attempt to extort money or other valuables or, in some instances, to extort political advantage or other noneconomic gain from the living, immediate survivors, or the larger community. Charlie Chaplin's body was stolen in order to obtain money from his survivors. There was an unsuccessful attempt to steal Elvis Presley's body, presumably for economic ransom. There were attempts to steal Abraham Lincoln's body. The last attempt almost succeeded, but the conspiracy was thwarted before the culprits could flee with the body. Following the attempted theft, Lincoln's casket was opened to verify that it still contained his body, and he was subsequently reburied and the grave was covered and encased in a large quantity of cement to ensure that his body could not be stolen in the future.

There have also been instances of criminals using the bodies of their victims as hostages or trading material in trying to negotiate escape or for some legal or judicial advantage.

One crime racket is selling merchandise allegedly ordered by a deceased person to the survivors. The offenders can identify persons who have recently died from local newspaper obituary columns. They then go to the home of the deceased and announce that they are delivering some object ordered by the dead person. Perhaps the most common item to be delivered is a Bible, often with the deceased person's name printed on it. This makes the purchase of the Bible even more compelling. Sometimes the stakes are much larger. The family may be told that the deceased owed large sums of money on land or business deals. Occasionally there is an attempt to blackmail the

family by threatening to reveal information that would harm the reputation of the deceased.

A variation of using the dead to economically victimize the living is the fraudulent omission of death-related services. Examples might include accepting money from a family for the service of scattering the remains of a deceased family member from a boat on the ocean, or from an airplane, and not doing so, but instead simply disposing of the remains. Bodies are legally supposed to be cremated individually. However, there have been instances of a crematorium cremating several bodies at one time, and then giving the families a sack of generic remains. There was even a case of a crematorium whose furnace had broken down, but they continued to accept bodies and collected money for cremating them, but simply carried the bodies to a nearby wooded area and dumped them there.

Clifton D. Bryant and Virginia Rothwell

See also Homicide; Manslaughter; School Shootings; Suicide

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Death-Related Music

Death-related music is that which deals with death either as a theme in lyrical content or musical composition or is in some way connected to the experience of death or cultural rituals that accompany death. The universality of death has made it a subject matter historically dealt with broadly in both classical and popular music. This entry provides an overview of the various ways in which death has been contextualized in songs of mourning, dirges, suicide songs, and murder ballads. In addition, the cultural role music has played in the rituals that inform the human experience of death such as the use of music in funeral rituals is described.

Social Construction of Meaning in Death-Related Music

Whatever meanings are associated with death should be understood in the context of the social construction of self, shifts in the evolution of identity, and the process of rationalization that prevails in modernity. Death has moved from the realm of the natural, often occurring in the home and attended to by family, to, in a contemporary sense, death as something taboo, having been subjected to medicalization and compartmentalization. Public displays of grief are unwelcome and often thought to be indicative of some psychological malady. This shift in thinking about death,

or rather not thinking about death, has resulted in the representation of death often in some horrific fantasy or sensational fashion, simultaneously making a spectacle of death while denying its natural certainty. In the wake of industrialization and the flourishing of technologically enhanced mass culture, natural death was relegated to the invisible sideline, whereas violent death became an important component of the fantasies offered up as entertainment, as in the case of war narratives, detective thrillers, Westerns, science fiction, horror films, and graphic comics. With respect to music, perhaps this void of representations of ordinary death in part helps to explain the postmodern curiosity in which death metal and reality rap indulge.

This shift in attitudes toward death offers us some insight into the fetishization of death in contemporary culture and ultimately enhances our sense of the cultural contradictions that inform death in the postmodern era. Death can be regarded as an "eternal sleep" or the gateway toward eternal life and, simultaneously, as something horrific to be avoided at all costs.

Functions of Death-Related Music

Death-related music may be understood most often in the context of the human need to externalize sentiments through social acts. Songs of mourning or loss are meant to serve the bereaved in the grieving process. Such songs may also figure in the social construction of one's own identity in that they mediate one's relation to the deceased. The representation given rise through song becomes symbolic of what once was but will never be again.

Just as is the case with visually recording death, songs of death may be read as both a means to keep the memory of the dead engaged in the living and a vehicle for the emotional distancing engendered in an attempt to manage the death of a loved one. In addition to offering the songwriter as well as the listener a cathartic vehicle for emotionally processing death, the recording of death-related music may give one the illusion of control over death.

Listening to songs that depict death in some fashion may also serve as an invitation to consider one's own mortality. Death-related music appropriates a fundamental component of the human condition, that is, the incontrovertible certainty of the demise of the individual. On some level, we are summoned to listen to songs that document the death of others so that we might be able to make some sense of our own.

Histories of Death-Related Music

Death has been a theme throughout the history of Western music. Death-related music is that which is often characterized as melancholy in mood, slowly paced, and making effective use of minor keys. Since classical music has its roots in the Church, death was featured as a prominent theme inasmuch as it was bound up with the Christian notion of death providing a dual gateway, one path leading to eternal salvation, the other, to everlasting damnation. Through death, one's being would be radically transformed. The *Dies Irae* serves as a good example of a classical music text wherein the theme of death is prominent. A "day of wrath, day of doom" is promised to the unfortunate souls.

Nowhere in classical music is the theme of death so intertwined in the work as in the case of Gustav Mahler (1860–1911), who composed a song cycle on the death of children, *Kindertotenlieder*, much to the outrage of his wife, Alma, who had borne him two daughters. In a cruel twist of fate, almost as if Mahler had summoned the "Grim Reaper," the eldest daughter died in 1907. Mahler's daughter's death came on the heels of his having been diagnosed with heart disease in addition as well as having lost his post in the Vienna Court Opera.

Funeral marches also figure prominently in classical music. Mozart, Beethoven, and Chopin all contributed to the classical origins of what might be considered funeral music. Chopin, in particular, is noted for the mournful tone of his piano sonatas employing minor keys to convey the heavy weight of grief.

Songs of Political Protest and Critique

Music has long been a vehicle for political protest. Folk singers like 1930s-era Woody Guthrie were very effective at using simple songs to make commentary regarding social injustice as in the case of his "1913 Massacre," which documents a bitter labor conflict involving copper miners in Michigan.

Seventy-three people were killed when an unidentified individual yelled "fire" during a Christmas Eve celebration; in the ensuing panic, the victims were trampled to death. Many believe the mining company had sent someone into the celebration to create the panic given that there was no fire.

Another interesting example of such a protest song that highlights social injustice is Lewis Allan's "Strange Fruit" (1939), made famous by the great jazz singer Billie Holiday. Lewis Allan was a pseudonym for Abel Meeropol, a Jewish schoolteacher and union activist. Meeropol was inspired to write the poem, which later became a song, by a newspaper photograph that documented the lynching of two southern black men. The lyrics against the backdrop of a haunting languid melody suggest that "black bodies swinging" are indeed a strange fruit born by "southern trees." While Holiday's record label was reluctant to release the recording, at the singer's insistence they did so and the track quickly became a catalyst for the anti-lynching movement and exposed the practice of lynching in a way that may have contributed to its demise.

Popular music was characterized to some extent by an element of protest in the 1960s that was led by Woody Guthrie disciple Bob Dylan. Vietnam War protest songs like Creedence Clearwater Revival's "Fortunate Son" (1969) implied a larger probability of untimely death for young working-class men who could not afford to escape the draft.

Songs of Salvation

Another variety of songs about death entertain the Christian notion that the soul will be transformed through death and either catapulted into eternal salvation or everlasting damnation. Gillian Welch's "Red Clay Halo" (2001) tells the story of a farm girl who can't seem to purge the red clay from her clothes or fingers in the hopes of finding a suitor and wonders aloud if, when death delivers her to "the other side," her gown will be gold instead. She concludes that God will not judge her for her modest, if somewhat muddy attire, as the boys at the dance do. Welch sings accompanied by a simple acoustic guitar, "I'll take a red clay robe, with the red clay wings, and a red clay halo for my head." Death is the great equalizer. In death social class is negated, as we are told the fruits of conspicuous consumption will not count for much on "judgment day."

Songs of salvation often recreate familial relationships that had been interrupted through death. In "Beulah Land" (1963), Delta blues legend "Mississippi" John Hurt invites the listener to "come on and go to Beulah Land," where he has a mother, father, and sister awaiting him "way beyond the sky." Though signifying the end of this life, death can be seen as an opportunity to live again and rejoin those previously lost through death.

Murder Ballads

Murder ballads are easily the most recognizable death-related songs in the history of popular music. Many murder ballads are derived from the balladry of old England, Scotland, or Ireland as in the case of "Knoxville Girl" (1956) popularized by the Louvin Brothers. "Knoxville Girl" is remade as a Tennessee legend, an Appalachian murder ballad, though it clearly derives from the old Irish ballad "Wexford Girl," which is itself a spin on the English ballad "Oxford Girl."

Often murder ballads offer a moralist tale told from the gallows, as in the case of Uncle Tupelo's "Lilli Schull" (1992). In "Lilli Schull," a traditional number, the singer tells how he murdered the poor girl despite her pleading, and then burned her body, and yet despite all of his callousness he still pleads for Jesus to save him prior to his own execution: "I beg him to save me like he did the dying thief."

Regret seems to figure prominently in the murder ballad. In "Killing Him" (2007) contemporary singer-songwriter Amy LaVere offers another jail-cell narrative, albeit from a female vantage point. The narrator in the song tells the story of a woman who had been promised "the sun and the moon" yet is apparently two-timed by her lover, leaving her frustrated at her inability to possess her man. LaVere poignantly sings, "She'd have to kill him to get him to stay . . . but killing him didn't make the love go away." Taking his life did nothing to alleviate her suffering, which she is left to ponder in her "8 by 8 cell."

Serial Killers and Sensationalizing Death

Another type of death-related song would be that which mythologizes the serial killer. Serial killers

have long perplexed criminologists as well as the public. Typically this type of behavior has been understood from either a demonic perspective or, more recently, a medicalized perspective. The lives of serial killers, mass murderers, and spree killers are fodder for the entertainment industry, and their positions as pop culture icons reflect the contradictions in our society with respect to violence and death. Such murderers are feared and abhorred, yet simultaneously romanticized and packaged as true crime antiheroes.

Popular music has featured songs about real and fictional serial killers. There are songs that mythologize the likes of Richard Speck, Jack the Ripper, Son of Sam, and John Wayne Gacy. The goth rock band Marilyn Manson is clearly a partial homage to Charles Manson. Sufjan Stevens's "John Wayne Gacy Jr." (2005) employs a haunting piano and strings melody with ethereal harmonies to convey the netherworldly narrative of the serial killer's terror. What is strange in this account is the singer's attempt to humanize Gacy by drawing vague parallels between himself and the murderer. Stevens sings "and in my best behavior I am just like him . . . look beneath the floorboards for the secrets I have hid."

The celebration of violent and spectacular death is a staple in the death metal genre, wherein bands such as Cannibal Corpse spin horrific macabre tales that can only be read as to create some spectacle of death, as in the song "Edible Autopsy" (1990). In fact, the entire genre of music seems to cater to some fantasy world that revolves around death and includes themes of extreme sexual deviance (i.e., necrophilia) and elements of Satanism. Reality rap, also referred to as gangsta rap, the subgenre of rap music divorced from its Afrocentric roots in which themes of violence and misogyny are packaged for commercial appeal, also offers a fair amount of gratuitous sensational death imagery. One of the subgenre's most recognizable rappers, Eminem, provides us with a good example of the type with "Kim" (2000), the graphic portrayal of a homicide fantasy wherein his own wife is his victim.

Existential Death Songs

Lastly, songs that explore the lived experience of death or ponder some existential questions regarding the end of life bear some mentioning. The Stanley Brothers popularized "Oh Death" (2000) as part of the hugely successful soundtrack to the film *O Brother, Where Art Thou?* The song portrays a conversation between the personification of death and a man whose time has come. "Death" provides the gateway to either heaven or hell and yearns not for silver or gold but rather one's soul. The singer pleads the refrain amid a dark melody, "Oh death won't you spare me over til another year."

Another example of this type of song questioning death or highlighting the absurdity of death is "Stop Breathin'" (1994) by Pavement. The narrative is one of battle wherein the lead character was "struck down by the first volley of the war." The deceased sounds as if he now inhabits some netherworld: "no one serves coffee, no one wakes up." The songwriter highlights the absurdity of war and the deceased's guilt over his own death: "stop breathin,' stop breathin,' breathe in for me now, write it on a postcard, dad they broke me, dad they broke me."

Suicide, Drug Overdoses, and Popular Music

Infamous suicides are part of the lore of popular music. Intent may be demonstrated as in the hanging deaths of folk legend Phil Ochs and Ian Curtis of Joy Division. Jazz musician Albert Ayler and soul icon Donny Hathaway both intentionally jumped to their deaths, Ayler into a river, Hathaway from a window. Rock suicides are ready-made for mythologizing as in the case of Michael Hutchence, lead singer of Australian pop band INXS, indie rocker Elliott Smith, and Nirvana frontman Kurt Cobain. Hutchence hanged himself with a belt in a hotel room, and despite widely reported speculation as to whether this was an autoerotic fatality, the rock star's death was officially ruled a suicide. Although Smith's death was initially reported as a suicide (he allegedly stabbed himself in the heart following an argument with his live-in girlfriend), the official autopsy report is somewhat ambiguous. While suggesting the strong likelihood of suicide, the report leaves open the possibility of homicide, fueling further mythologizing. Cobain shot himself at the height of his popularity. The singer-songwriter had struggled with heroin addiction and was apparently uncomfortable with his meteoric rise to stardom, which was difficult to reconcile with his punk rock ethic. At the time of Cobain's death, rumors swirled that

his wife, herself a rock star of sorts, was implicated somehow in his death. However, the death was officially ruled a suicide.

The legendary drug overdoses that litter rock mythology may be read as possible suicides. Drug use and alcohol figured prominently in the deaths of performers as notable as Janis Joplin, Nick Drake, Frankie Lymon, Jim Morrison, Gram Parsons, and Jimi Hendrix. Intent is less clear in these cases, but the fact remains that they all died of self-inflicted injury.

Jazz Funerals

The New Orleans jazz funeral is an interesting tradition, an emergent of blended African cultural death rites, which marries death and music. Borrowing from the Dahomeans and Yoruba of West Africa, American slaves carried with them the African ideal of the need for a proper burial to ease the transition of the soul to the spirit world. In fact, social aid and pleasure clubs, lodges, and the like would often guarantee burials for members, suggesting an early form of insurance.

Jazz funerals are unique to New Orleans and involve a procession by a brass band accompanying the family and friends of the deceased from the church, funeral home, or house of the deceased to the burial ground. On the way to the cemetery the band plays a mournful dirge or old spiritual, but upon "cutting the body loose" they will strike up a more rousing number like "When the Saints Go Marching In." The recession signifies a celebration of the deceased's life. New Orleans jazz great Sidney Bechet was known to have said, "Music here is as much a part of death as it is life."

Conclusion

Death has long occupied a place in the larger popular culture, and the same may be said with respect to popular music. Death-related music serves several functions in the culture, whether as art or a prop in the grieving process. Though songs that are informed by death may serve as a cathartic tool for some, clearly some usage of death as a theme in music tends toward the sensational and spectacular as a means of entertainment. There is no singular usage of the theme of death in music. In fact the various ways death is contextualized in music speak to the contradictions that shroud death in contemporary culture.

Charles Walton

See also Depictions of Death in Art Form; Drug Use and Abuse; Funeral Music; Popular Culture and Images of Death; Serial Murder; Suicide

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Death Squads

Death squads are secretive or clandestine organizations that generally exist outside of formal governmental or military structures and usually are formed on an ad hoc and irregular basis. They are designed to kill people and carry out other violent acts in order to terrorize a civilian population. These acts of violence are all extrajudicial, and though death squads may commit some random acts of terror, their targets are usually quite specific. Significantly, except in the rare case where they are formed by an insurgent or revolutionary group, death squads operate with the support, complicity, or acquiescence of the state, or at least some faction of it. In most cases, individual members of legitimate organs of the state (the army, the police) participate directly in death squads, and their work is usually steered in some way by elements of legitimate authority. Yet at the same time, death squads almost always include private forces and interests, and they develop considerable independence. Death squads are therefore almost always a form of state violence, targeting civilian or insurrectionary elements or actors within a state, and do not occur in the context of war between regular armies of sovereign states.

Yet they exist in a liminal position, partway between legitimate state organs and private interests. Key to distinguishing death squads from other forms of state violence and terrorism is their covert nature. This allows elites and the state to maintain "plausible deniability," by claiming that they are not involved. This is usually a transparent lie, but it is crucial to the existence of death squads. They exist so that the state may plausibly deny complicity in terrorizing its own people.

Death squads must be distinguished from assassins, vigilantes, and terrorists. Death squads kill on a greater scale and make terror their objective in a way that sets them apart from assassins, who typically focus on one or a very small group of victims. The acts of death squads are often claimed to be those of local or community vigilantes, yet death squads are not genuinely spontaneous and are directed by the government (and/or private interests allied to the elites) in most cases. They are also usually more widespread than true community-based vigilantism. Finally, death squads are an aspect of state terrorism and are used by states or factions within states to terrorize their own people. They are a terrorist tactic, but one used nearly always by states against their own people, and not by insurgent or revolutionary terrorists. While terrorists tend to kill indiscriminately, death squads kill a specifically targeted group of people.

Scope

Death squads have existed in every region of the world. The best-known cases have been in Central and South America, for example, Guatemala and El Salvador, but there have been death squads on every continent and in modern, industrialized states. Death squads are not limited to the third world or any particular region. Important instances of the use of death squads include, but are not limited to, El Salvador 1971–1991, Guatemala 1954–2000, Nicaragua 1981–1995, Argentina 1974–1983, Chile 1973–1990, Brazil 1960s to date, South Africa 1969–1993, Serbia/Bosnia 1992, Spain 1983–1987, Uganda 1971–1979, Zaire 1980s, Algeria 1960–1962 and 1990s, India (Punjab, Jammu, and Kashmir) 1980s and 1990s, Sri Lanka 1970s to date, Indonesia 1980s to date, Philippines late 1980s, and United States 1865–1871. Death squads were first used in the 19th century, though they have become commonplace only since World War II. One reason for this is that the cold war and the expansion of global media both brought increased scrutiny of civil rights violations, making it increasingly important for governments to assert plausible deniability when using violence and terror against their own citizens, for fear of losing legitimacy. This has entailed a growing paradox, for as scrutiny of human rights violations has sharpened, states have increasingly turned to covert violence, making the uncovering of the true culprits and the fate of the victims increasingly difficult. Hence there is a need to find new ways for the resolution of domestic conflicts, such as truth and reconciliation commissions and amnesties for killers who are willing to confess their crimes and provide information on the victims.

Theories

Though the scholarly literature on death squads is rather limited, many theories have been proposed to explain them, and these theories often overlap with more general theories on the nature of state violence and terrorism. Early theories tended to focus on the reasons for using death squads within particular states. The first major explanation was that death squads are produced by authoritarian or fascist states. This is sometimes true but is actually a comparatively rare case, if only because open dictatorships have less need to maintain plausible deniability. Subsequent theories held that death squads were the product of "weak states" or were an inevitable response to the existence of domestic insurgencies, though neither of these theories applies to all instances of death squad use. For a time some theorists tried to explain death squads as a form of vigilantism; these theorists emphasized the important fact that death squads include private interests and develop their own agendas, but they also tended to exaggerate the spontaneity of death squads and to accept as true what is really a transparent attempt to hide state or elite involvement. On the other hand, there is a recent shift in focus of many death squads today, toward killing homeless people or petty criminals, but again, the violence does not arise spontaneously out of a community, but is carried out by perpetrators connected to the state.

Current theories tend to see death squads in a more global perspective and stress the interplay of

local and global forces. Some theorists in the 1980s pointed to the cold war and specifically to U.S. military aid as the origin of death squads. More recent theories stress a global culture of violence and militarism, even as they also cite the importance of the global trade in arms and "security" industry. Other modern theories see state terrorism and therefore, potentially, death squads, as an almost inevitable product of social stratification, or a manifestation of routine social control run amuck, though these latter approaches are surely too broad unless carefully rooted in a specific local context. Other theorists implicated modernization and elite resistance to it in the use of death squads.

Another fruitful avenue in recent years is to explain death squads as a part of a larger spectrum of government "subcontracting" of services and responsibility, which ranges from privatization of essential state services over private police forces all the way to the privatization of violence and death squads. Some commentators have even made a specific link to neoliberalism in this regard, although state "subcontracting" exists in states that do not necessarily espouse neoliberal economic theories and seems to be a function of growing state responsibilities combined with decreasing resources.

Any comprehensive future explanation of death squads will have to include global, regional, and local factors, including the importance of cultural differences. The phenomenon is so varied and so widespread that only an integrated approach sensitive to all levels of influence (global and regional, as well as local) and careful to include local specificities will be able to adequately explain it. Given the increase in terrorism, the proliferation both of "small wars" and the means to fight them, and the growing level of media scrutiny, it is likely that death squads will continue to proliferate, but they will mutate in ways that will increase their deniability.

Bruce B. Campbell

See also Assassination; Atrocities; Terrorism, Domestic; Terrorism, International

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Death Superstitions

Superstition is derived from the Latin *superstes,* meaning "to stand over." Thus, the concept refers to the practice, based on belief, of standing over rationality of thought. In general, death superstitions have a negative connotation because these are based on unproven scientific validity. But the validation of beliefs surrounding death cannot be determined because the deceased are unable to participate in follow-up studies, thereby leaving the area of death and dying as a natural breeding ground for superstitions to evolve.

Such death superstitions vary across cultures, though there are some shared commonalities. Understanding the diversity of death superstitions increases one's sensitivity to the sources of the fear of death within diverse cultures. Many, if not most, death superstitions can be categorized within the timeline of the dying process.

Superstitions and Signs of Death

Most death superstitions refer to the signs of death as represented by the actions of animals and insects, human actions, and dreams. Blackbirds and crows, for example, characterize these death omens inasmuch as their presence represents a sign of death. Some superstitions prescribe the rare behavior of birds that include flight into a house, tapping on a window, or crying abnormally during the night. Even the number of times such cries or tapping on the window (usually three) is prescribed. Dog howling for no reason is yet another death omen.

Insects serve as a medium of the death omen. In Britain and Ireland, there exist beliefs that special sounds made by beetles and crickets represent signs of approaching death. It is believed that these insects and animals possess the ability to identify clues surrounding death that lie beyond human reach, possibly because the smell, body temperature, or wavelength of the dying person attracts the animals' attention. Less often reported death omen phenomena include the dropping of pictures from walls, unexplained cracking of glassware, breaking of a mirror, or a clock stopping at a certain time.

Death superstitions also refer to action. If someone points a finger at a funeral attendee, it is thought this gesture will bring death to that person. To maintain one's breathing while passing a cemetery is believed to be absorbing of the spirit that causes death. Experiencing dreams of one's death also is taken as a sign of impending death, as is meeting a deceased loved one in a dream.

Superstitions and Dying

Superstition rules related to responding to the dying also exist. Doors and windows should be open wide and unlocked when someone in the house is dying. Mirrors are to be turned inward to avoid reflections, and all knots should be untied. There is a belief that if the eyes of the deceased person are open, another death will soon follow. In Chinese culture, open eyes symbolize the unfinished business of the deceased. Thus, the bereaved try to fulfill the wishes of the deceased, thereby hoping to avoid future misfortune.

Chinese culture emphasizes the importance of family members witnessing the death of loved ones, especially the eldest son. If this action is not fulfilled, it is considered that the deceased did not engage in good deeds while on earth. The crying of family members during the moment of death is thought to disturb the transition of the spirit of the deceased. From the Buddhist point of view, it is urged that peaceful chanting occur.

The Funeral and Body Disposition Process

In Western culture, touching a corpse is believed to bring good fortune. The phrase "dead hand," referring to the hand of a corpse, is said to have healing powers. It is also believed that infertility can be cured through touching the dead hand. Similarly, the sheet wrapping of the corpse is thought to carry the same healing power.

In Chinese culture, the corpse is believed to have a certain *qi* that is hazardous to the health of those who come in physical contact with it. Thus, funeral workers wears gloves while handling the corpse, and family members are not encouraged to touch, except for stroking the hands over the eyes to make them close. In Chinese culture, recently bereaved persons avoid visiting the house of friends or relatives during the first month after the funeral because they are thought to carry bad qi that will cause bad luck. Moreover, attendance at funerals and weddings within that same period is not allowed because it is believed that the clash of these events will result in misfortune for both parties.

But superstitions also have the positive function of inducing a sense of death being beyond human control. After death occurs, bereaved persons look for such clues or signs. The externalization of locus of control reduces personal guilt as to the cause of death. On the other hand, if prescribed superstitions are identified but death does not occur, family members become increasingly conscious of health and family relationships. As for the death omens, these serve as guidelines for the individual to be more respectful toward funeral processions, as well as all deceased persons.

In summation, differences in superstitious views hold different functions. The Western approach encourages a greater connection to the deceased, thereby testing the reality of death. Touching the corpse of the loved one facilitates closer connection and communication. The Eastern approach addresses issues relating infectious control to avoidance of direct contact with the corpses,

thereby reducing the risks of spreading contagious diseases. Restriction of social life, for the Chinese in particular, provides space for the bereaved family to consolidate family ties and have time for personal reflection.

Amy Y. M. Chow

See also Ghosts; Holidays of the Dead; Mythology; Popular Culture and Images of Death; Symbols of Death and *Memento Mori*; Witches; Zombies, Revenants, Vampires, and Reanimated Corpses

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Decomposition

Decomposition is an essential part of the life cycle of any living organism (human beings are no exception) as it is the means by which nutrients are returned to the soil to nourish other life forms. Shortly after death, the body begins to undergo a process whereby the tissues begin to break down and decay; this process is referred to as decomposition. Throughout the stages of decomposition, bacteria and insect activity are the primary means by which this process is accelerated. Due to the popularity of *CSI: Crime Scene Investigation* and other similar TV series, this information is increasingly available in the public domain. *Taphonomy* is the science that studies decomposition and decay of an organism over time; this discipline has identified a series of stages that human bodies undergo after death.

Disposal of Dead Bodies

Many believe that a dead body presents a sanitation and health risk to the living that may be, in part, due to the foul odors emitted when a body begins to decompose. However, although the World Health Organization provides directions for staff to remove dead bodies swiftly in cases of disasters and emergency situations that result in many deaths, this is not specifically related to health concerns. There is considered to be little risk of communicable disease in the event of death resulting from trauma, although decomposing bodies will certainly contaminate water sources and can cause a type of gastroenteritis in survivors. The distress associated with decomposing human remains, with its attendant sight and smell ever present, highlights issues associated with human frailty and mortality and perhaps exacerbates feelings regarding a fear of death itself. The swift removal of bodies in disaster situations is recommended mainly for psychological reasons: in order to minimize distress caused by the sight and smell of decomposing bodies. This removal will also enable cultural, religious, and traditional obligations to the dead to be addressed by the community and is linked to providing for the mental health of a traumatized community.

Funerary Rites

Many cultures associate the decomposition of human remains after death as being unclean, possibly due to the resultant odors and visual impact upon the body of the decomposition process itself. This has led to various means whereby the decomposition process is not experienced by the living. One of these involves the burial of the entire body, usually involving some type of ritual as indicated by religious and/or secular requirements; in many instances religious beliefs require that the corpse be interred whole. Other cultural and religious beliefs differ: For example, Hindus require that the corpse be cremated, while the ancient Egyptians preferred the mummification of the corpse. Some cultures use other means, such as the Tibetan sky burial, the Comanche platform burials, and the

Zoroastrian tower of silence, each of which used a type of platform upon which the dead were placed to be exposed to the elements and to predators.

Stages of Decomposition

After death, the process of decomposition begins. The first of these stages is called "fresh" and this begins immediately as the body begins to cool and bacteria begin to break down the body. It is during this process that the gases and other substances produced serve as an attractant to insects. The second stage is called putrefaction; increased bacterial activity leads to the bloating of the body as gases formed during this process cause swelling, especially of the abdomen and areas around the face. Increased bloating and the resultant odors released as well as the bacterial activity involved in this process again serve as an attractant to insects. During this stage the skin begins to break down and become delicate. As decomposition becomes more advanced, the skin becomes more discolored, moving from a green coloration in the early stages to more brown toward the end of this stage. The third stage of this process is called black putrefaction, where the bloating has reached such a stage that the body itself breaks apart to allow the gases that caused this bloating to escape. This also provides greater access for insects. In the next stage, called butyric fermentation, the body moves on from the liquefying process of the earlier stages and begins to dry out. The internal organs increasingly disappear, as does the smell associated with the earlier stages as the body begins to mummify and move into the final stage of the process. This stage is referred to as dry decay, and it is at this stage that the bulk of the soft tissues of the body have decomposed and the longest stage of skeletonization begins. How long this part of the process takes depends upon the conditions, but this is mainly affected by the type of soil and water conditions surrounding the remains.

Preventing Decomposition

Over the centuries people have tried to slow down or even prevent the decomposition process from occurring. The use of a coffin for the burial of human remains is one way to slow down the decomposition process as was the mummification of the body, a process preferred by the ancient Egyptians. Embalming of human remains is considered one of the more successful ways to achieve this aim and has been used to good effect to preserve the remains of famous figures like Vladimir Lenin and Eva ("Evita") Perón.

Decomposition in Cultural and Religious Beliefs

Many cultures and religions have beliefs that are connected with the decomposition of human remains. Hindus believe that after death, they will be reincarnated. However, they also believe that it is impossible for the soul to enter a new body until the current body has entirely decomposed. This may be one of the reasons for the use of cremation as the means of disposing of human remains after death. Vikings believed that the soul was located within the body and could only be set free to begin its journey to the afterlife through a process of decomposition or cremation. Zoroastrians consider a dead body to be unclean; to prevent it from contaminating either the earth or fire, they expose their dead to the elements on specially built platforms.

Often a culture will have taboos related to dead and/or decomposing bodies. The Māori, for instance, consider those who have touched or prepared a dead body for burial to be unclean, and these people are not allowed to interact with others for a period of time. In modern Western cultures, although these types of taboos are often unidentified or unacknowledged, it is possible they still exist as we tend to remove ourselves from interacting with the dead and preparing them for burial as was common in the past. Now others, such as doctors, nurses, and funeral directors, prepare our loved ones for the grave while we remain at a distance, safe (at least for now) from the immediate threat of decomposition.

Barbra McKenzie

See also Body Farms; Cemeteries; Death Anxiety; Funerals; Putrefaction Research

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Defining and Conceptualizing Death

Death is generally considered the only certainty of life. At the same time, however, no matter where or when one is living, death is also regarded the ultimate mystery of human experience. The answer to the question "What is death?" is far from universal, and the concrete ways of defining and conceptualizing death vary from culture to culture. Furthermore, multiple definitions of death exist within the same culture because of the various situations and perspectives from which they are acted upon.

The question arising from the topic of death is how to be sure that the same reality is being talked about. For instance, does the concept refer to one's own death, or to the death of another? Is it a physical death here and now or an abstract idea in the past or future? Is it possible to define death at all? One could further argue that the act of making death knowable and controllable through explicit definitions, as is the case in this encyclopedia, exemplifies a typically Western project of truth seeking.

By the beginning of the 21st century, in most Western contexts biomedical definitions of death, constructing death as the irreversible end of life, are a taken-for-granted discourse. Some researchers of death hold that in such a rational or disenchanted world, death appears as a threatening and destructive immensity that cannot be averted and so must be hidden or avoided. By consequence, individuals would no longer have images and conceptions to fall back on. Other researchers, however, find it more accurate to say at the beginning of the 21st century, images of death are omnipresent. In their view, formerly shared definitions and conceptions of death, like from the Christian tradition, have not disappeared but rather are fragmented and personalized.

Death belongs not only to human nature but also to the shifting world of cultural meanings and social practices. Hence, ways of defining and conceptualizing death are dynamic and multiple. First, it is important to mention that death can only be made present through metaphors: conceptual constructs that are pervasive not only in language but also in thought and practice. Second, the definition of death depends on the social context rather than on one primordial essence. Third, understanding death inevitably involves defining life: The concepts of death and life are dynamically related to one another.

Defining Death Is Making Death Present

Death is simply impossible to imagine. Every statement on death refers to symbols rather than to an empirical reality. Death is hence conceptualized and acted upon as a process (e.g., dying), an instance (e.g., the Grim Reaper), a state (e.g., the absence of life), or a moment (e.g., one's final breath). It is only in such metaphors that death can be experienced as a real entity. In other words, defining death is an act of presentation, rather than one of representation. It is a performative act: Each definition of death fixes a specific content and brings forth death in one way or another. Whether in a scholarly publication or in social practice, death is visually or verbally defined through metaphors.

Visual and Verbal Presentations

Sometimes, death is made present through personification, especially in artistic visualizations. A clear illustration is Pieter Brueghel's painting *Triumph of Death* (1562), which shows a spectacular image of death: living skeletons coming to get insignificant creatures in a dark landscape. Another is Roger van der Weijden's *Descent From the Cross* (1435), in which the focus is on the grieving Virgin, who seems to be dying along with her son. In this painting death is made present as a far more intimate and emotional process.

Quintessential examples of verbal definitions are to be found in the writings of philosophers who have always, like artists, tried to get a grip on death. For Epicurus, death is literally nothing. It is not our concern: When we live, death is not there, and when death is there, we are not. Socrates and

Plato do not define death as "nothing" but as the liberation of our immortal soul from the prison of the body. For the 20th-century German philosopher Martin Heidegger, death is a certainty eliciting both fear and creativity. We anticipate death as a horizon or a condition of meaning: Human existence is to exist in relation to death.

Scholarly and Practical Presentations

Definitions of death can be spelled out in detail by scholars from fields as diverse as biology or theology. Like sexuality, death was earlier defined in 20th-century academia by physicians and psychologists, who constructed the concept as a natural fact of human experience. Still, no single discipline can claim sole authority concerning the definition of death. As illustrated by numerous conferences on the subject, the concept of death invites a multidisciplinary environment that brings together many focuses and approaches. Clear descriptions are of great importance because they make explicit the unspoken assumptions in relation to such issues as abortion, euthanasia, and organ donation, but each approach to conceptualizing death is inevitably limited. Most often, however, death is encountered through social praxis in rather implicit and intuitive ways. In cancer, for example, death is becoming present as an actor and being reacted upon within one's very own body.

Social Contexts of Defining Death

Death takes particular shapes in different environments, such as a home, the media, or the political institution. Furthermore, what death stands for depends on the social perspective and relationship. For instance, when a funeral undertaker is laying out a dead body, multiple and fluid contents of death emerge. Whereas for the professional, death is socially constructed as a concrete but anonymous object, for family members the corpse is still a unique subject with a personal past. Thus, when somebody dies, multiple definitions of the body and of death are simultaneously enacted. From the perspective of grief, death is not so much being defined by us as it is defining us. It becomes an intimate death for those who are related to the dead. Yet, generally death is defined and experienced from a relative distance.

Intimate Death

The death of a beloved is experienced in a highly intimate way. It may involve existential questions or a loss of self, as this self is socially shared with the deceased. When the death of the other becomes partially the death of the self, it is believed that death controls us, rather than our controlling death. Western psychological discourses often conceptualize death as the trigger of grief experiences. It is considered to cut deeply into one's guts and change one's further life. In an ongoing and ambiguous dialectic of letting go and continuing bonds, survivors are forced to search for a *modus vivendi* with the different forms of loss. Death in the context of grief is an upsetting and shattering reality. Hence, the aim of grief work is implicitly described in advisory books as the capacity to define or "place" death, instead of having death define those who grieve.

Distant Death

Death does not always involve grief. First, death can be defined as an abstract reality. Thinkers and writers discuss death in a rather level-headed way in intellectual texts. Demographers describing mortality rates and newspapers estimating the number of casualties define death in abstract figures. Second, death can appear as an embodied but anonymous reality to professionals like pathologists and coroners. Their technical approach secures a safe distance toward a depersonalized body and implicitly defines death as an object rather than subject. Third, death can also become a spectacle: In fantasy, horror movies, video games, and media coverage of car crashes, murders, wars, and disasters, death can be counted on to fascinate a large audience. The audience does not participate in such deaths; rather, they watch and forget. These deaths are socially defined as controllable death, as objects that can be manipulated, talked about, and distanced from.

Defining Death Is Defining Life

For many researchers, death is an indicator of life revealing central social processes and cultural values. Moreover, death is often considered the mirror of life because life cannot exist without death and vice versa. Whether in a dichotomous

or hybrid relationship, death is defined in terms of life.

A Dichotomous Relationship

From the 18th century onward, medical science came to define life and death as two separate entities. According to secular definitions, death is conceived as the irreversible extinction not only of consciousness and sensation but also of the individual personality. Current dictionaries hence emphasize the materiality of the human body and, more specifically, its absence of life. For instance, the 2005 edition of the *Oxford Dictionary of English* defines death as the action or fact of dying or being killed; the end of the life of a person or organism; the state of being dead; and the permanent ending of vital processes in a cell or tissue. Conversely, the same dictionary still included in its 1933 edition "the loss or want of spiritual life, the being or becoming spiritually dead."

From the biomedical or materialistic perspective, death ushers in the biological process of decay and thus terminates the human story. In other words, death is defined as the absence of life. How specific transformations of the body are related to the concept of death varies greatly, depending on the dynamics of science and technology. Initially, the moment that embodies the boundary between life and death was the cessation of breathing. Later, the stoppage of the heart served as the central metaphor for the ending of life. Finally, with recent medical developments, the beginning of death and ending of life have moved to the moment of brain death. Remarkably, progress in biomedical science and technology did not lead to greater clarity of the concept of death. On the contrary, it rather contributed to the complexity of contemporary definitions and, hence, to substantial debate on the timing of organ donation.

A Hybrid Relationship

Death is not always socially constructed as a complete break, the antipode of life, or an irreversible ontological change. In many non-Western cultures, death is not the destruction of a life on earth but rather a transitory phase in the life cycle. Decay is creative, and the deceased live on through their surviving relatives. In traditional Western contexts, in which religion served as the main source of definitions and conceptions of death, some form of actual survival or even enhancement of individual personality was postulated. In postmodern societies, with the growing authority of the self and the cultural variety of religious beliefs and practices concerning dying and grieving, the dichotomous view of a firm boundary between life and death is being challenged. Actually, every society has its hybrids. At the beginning of the 19th century people were afraid of being buried alive, as medical practice was questioning former commonsense boundaries.

Although at first sight, categories of life and death seem clear-cut and typically confined to our views on the body, a closer look reveals that the relationship between the body and the self, and between life and death, is much more fluid and hybrid. The dichotomy of life and death has been debated and questioned not only from a theoretical viewpoint but also from a medical viewpoint. The binary opposition of life and death in the social practice of hospitals is being challenged at both ends of the life cycle. Both stillborn babies and persons in a vegetative state are currently considered as hybrids, confusing the taken-for-granted categories of life and death. Although not assigned to being ontologically alive, both stillborns and the brain dead are treated as living humans. When they are being cuddled or washed, not only is there an intricate connection between the body and social identity, but what also becomes apparent is the constructed nature of the concepts of life and death.

Jan Bleyen

See also Appropriate Death; Brain Death; Death, Clinical Perspectives; Death, Philosophical Perspectives; Death, Psychological Perspectives; Death, Sociological Perspectives; Medicalization of Death and Dying; Personifications of Death; Popular Culture and Images of Death

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Deities of Life and Death

Diverse cultures of antiquity mythologized a diverse set of deities of life and death. Most reside in a land of life after death, sometimes as judges, and some are male while others are female. Some deities of life and death rule as couples in love, others govern as a family; some are gracious hosts, and others are haunting ghosts. Some deities are agents of torment who punish, whereas others are angels of transformation who transport the dead to life.

In this entry the diverse deities of life and death are selected from Africa, Asia, Australia, Europe, and the Americas to illustrate the global universality of the topic without regard to any particular definitions or interpretation. Mythologies about deities of life and death from India, Egypt, Greece, Haiti, New Zealand, and Finland have been selected for the unique way each addresses and answers questions about the relationship between life and death.

Historical Presentation of the Deities

Scholarship on the deities of life and death is nearly unanimous in discerning, declaring, and defending one universal theme; however, there is no consensus concerning exactly what that theme might be. For this reason deities of life and death have no universal definition because no single unifying characteristic is common to all deities of life and death. According to one interpretation, the meaning of the motif of the dying and rising god entails the devotees' vicarious experience through the transpersonal mystical identification with the god or goddess.

According to another interpretive tradition, the deities of life and death are metaphors that personify the cyclical nature of agricultural seasons that rotate between the death of winter and the rebirth of spring. In still other traditions, deities of life and death serve as guides or psychopomps who help the deceased navigate the way to life after death. For still others, deities of life and death dramatize the interdependence of life and death; the life of one is sustained by the death of another.

Despite the conflicting and competing definitions and interpretations of deities of life and death, the universality of the topic consists of the questions engendered by a global curiosity about the relationship between life and death. People everywhere have wondered about that relationship. This wonder is embodied in the many mythologies that entertain and provide responses to the questions people pose about the relationship between life and death—questions such as What happens after death? How are people judged and who judges them? Who has power over life and death? Why do people die? What does it feel like to be dead?

India

What is the meaning and purpose of life in the face of death? On the South Asian subcontinent, Yama, the mythical first man to die, has since then been the guardian god of deceased ancestors in the afterlife. Yama is invoked in the liturgy of every Hindu death ritual. Mythologies of Yama are narrated in 2nd millennium B.C.E. Vedic literature is nearly as old as the Pyramid texts of ancient Egypt. Yama is described as the head of the grateful dead and the ruler of the departed souls, who prepares a place for the dead to rest in the world of the ancestors. In addition to being the first person to die, Yama was the first to discover the path leading to the other world. One ancient Sanskrit text records a young boy's dialogue with death. In a fit of anger, a father offered his son as a sacrifice, but when the son ascended in the sacrificial ritual flames toward the realm of Yama, he discovered that Yama was not at home. When Yama finally returned, as consolation to the boy for making him wait so long, Yama granted the boy three wishes. The first two requests were easy for Yama to fulfill. The boy asked to be restored to life and reconciled with his father, and he requested

instruction in the fire sacrifice that leads to heaven. The boy's third wish was to know the mystery of what happens after death. He asked Yama to resolve the controversy about whether or not there is life after death. Yama begged the boy not to ask that question and offered to fulfill any other wish he might have, but the boy could not be dissuaded and insisted that Yama grant this third wish. Yama acknowledged that not even the gods knew how to answer this question; nevertheless, Yama disclosed the mystery by revealing the reality of a self that is never born and never dies and recommended that the boy search for that self.

Egypt

Do the just and unjust have different destinies after death? How are people judged and by whom? What happens to one's body after death? The Egyptian myth answers these questions with one of the oldest gods of life and death, Anubis, as described in the Pyramid Texts of Egypt from the 3rd millennium B.C.E. Anubis was the chief god of the dead, depicted as a man with the head of a jackal, a scavenger who roams cemeteries, digging up the dead and feasting on their flesh. The myth of Anubis satisfies Egyptian curiosity about whether or not people keep their bodies after death. He cares for the dead and is the legendary inventor of the process of embalming, which he first administered to Osiris, who was killed and dismembered by his brother and subsequently reassembled by his sister and consort, Isis. In the Egyptian concept of divine kingship, the king, at death, became Osiris and the new king was identified with Horus, the son of Osiris and Isis.

Osiris also represented the power that brought life out of the earth. Thereafter Osiris replaced Anubis as god of the underworld while Anubis maintained his occupation and identity as embalmer and caretaker of the dead. As the guide who held the scales by which hearts were measured against the feather of ma'at, Anubis addresses the question of different destinies for just and unjust people in the underworld. If the deceased's heart was as light as the feather, then it would be presented to Osiris, but if the heart was heavier, then it was fed to Ammit and destroyed.

As psychopomp of the afterworld, Anubis prepared the bodies of the dead and guarded over them and the places that house them. During the death ritual ceremony, priests wear the mask of Anubis as he is responsible for reawakening the senses of the deceased. Anubis's enduring prominence reflects the ancient Egyptian cultural preoccupation with preservation of the body to ensure that the dead will live happily in the ever after just as they did in Egyptian society before death.

Greece

Ancient Greeks called one of their numerous deities of life and death Hades. Myths surrounding Hades answered many of the same questions that Anubis answered in the Egyptian myth: Who judges the dead and by what criteria? Is there a different destiny for the just and unjust in the underworld? When a person died, Hermes, the messenger of the gods, led the dead to the banks of the river Styx, from where Charon, the ferryman, would carry the dead across the river to the underworld island, also called Hades. Once in the underworld the dead person's life would be judged and determined to be good or bad. People who were good would go to Elysium, where they would be happy and have the possibility of rebirth into another body someday after drinking from the river Lethe, the waters of which would make people forget their previous life; however, people who were bad would go to Tartarus where they would endure punishments that fit their crime for all eternity.

The ancient Greek myth also accounts for why the seasons change. As the king of the underworld, Hades oversaw everything but he was an unhappy king because he had no wife. One day he saw Persephone, Demeter's beautiful daughter, and decided to kidnap her. Demeter, the goddess of fertility and growth, searched frantically for her missing daughter. When Demeter discovered that Hades had kidnapped her daughter, she demanded that her daughter be returned to earth. Unfortunately, while in the underworld, Persephone had eaten some pomegranate seeds; consequently Zeus determined that she had to divide her time between Hades and Earth each year, which accounts for the recurring, cyclical seasons of nature. When Persephone is on earth, her mother, Demeter, is happy and everything blooms; conversely when Persephone is in Hades, everything dies.

Haiti

Who has power over life and death? Is there anyone to help the deceased make the transition from death to destinies beyond? Adherents of voodoo, as it is practiced in Haiti, believe in a family of spirits called Ghede, a deity that embodies the powers of death and fertility. The father of the family, Io Baron, also know as Baron Samedi, was the first man to die after which he subsequently raised the rest of his family from the dead. His wife, Maman Brigitte, is spiritual mother to the innumerable members of the Ghede family, who are esteemed to become mind readers and who are extremely wise because their knowledge is an accumulation of the knowledge of all deceased people.

Ghede are psychopomps who control the eternal crossroads which everyone must cross to go to Guinee, the underworld. In the Haitian view of reincarnation, Ghede decide if a person in the underworld will be reincarnated as an animal and whether a sick person will die and join him in the underworld or recover and remain on earth. Therefore, in Haiti Ghede answer the question of who has power over life and death. Ghede are also the protectors of children, desiring that they should live a full and long life before they die. Ghede are the protectors of cemeteries and popularly represented by an undertaker, wearing all black, including dark glasses.

New Zealand

Why do people die and how did death enter the world? The indigenous inhabitants of New Zealand, the Māori, tell of Hine-nui-te-po, Great Lady of the Darkness, Great Woman of the Night, ruler of the underworld, and the goddess of night and death. Her husband is Tane, the god of forests and birds. Upon discovering that she was simultaneously Tane's wife and daughter, she fled to the underworld. While Tane remains on the earth to care for their children, Hine-nui-te-po, Great Woman of the Night, Great Lady of Darkness, presides over the underworld where she has been reigning since long before human beings came into existence. Death entered into the world through Maui, who tried to make humanity immortal by crawling through the body of Hine-nui-te-po, Great Lady of Darkness, goddess ruler of the underworld, while she slept. His plan was foiled when she awoke and crushed him with her vagina, distinguishing Maui as the first man to die and the one responsible for introducing mortality into humanity.

Finland

How does life after death feel? In Finland's pantheon, Tuoni and Tuonetar are the god and goddess that ruled over Tuonela, the land of the dead, where death is pleasantly described as a deep sleep for all eternity. Tuoni and Tuonetar rule Tuonela with their hideous, grotesque daughters Lovitar, Kipu-Tyttö, Kivutar, and Vammatar. All people, good or bad, go to Tuonela, which is described as a dark place, protected by a dark river. In Finnish mythology the world is formed from a waterfowl's egg, where the sky is the top part of the egg supported by a column at the north pole. The movement of the stars around the dome causes a great wind, which allows the souls of the deceased to go outside the world and enter Tuonela.

The universality of myths about deities of life and death, however defined, signals humanity's universal propensity to imagine, personify, and project anxieties and aspirations, dreads and dreams, visions and values into mythologies that address, entertain, and answer the most fundamental existential questions people pose about the relationship between life and death. Life and death are dualities, that is, polar opposites that are mutually exclusive categories. One is dead or alive, not both. Yet, in mythology, deities of life and death embrace, embody, reconcile, and resolve life and death into a single coherent world of meaning, even if that meaning is subject to competing and conflicting interpretations.

William C. Allen and Brittney L. Coscomb

See also Day of the Dead; Holidays of the Dead; Mythology; Valhalla; Zombies, Revenants, Vampires, and Reanimated Corpses

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Demographic Transition Model

The demographic transition model, which is attributed to demographer Frank Notestein, describes population changes in fertility and mortality as societies make the transition from premodern to postmodern eras. In essence, the premodern regime of high rates of births and deaths changes to low rates of each through the process of modernization.

Much has been written about this topic regarding the pace, pattern, and causes of this transition. This entry first describes the basic demographic transition model and describes some of the different ways countries have moved through the transition. The next section describes the epidemiologic transition theory, which focuses primarily on mortality transitions. The third section examines the effect of the demographic and epidemiologic transition on population size and structure. Discussion then focuses on the possible causes for the mortality and fertility declines. The final section considers current and future trends in demographic and epidemiologic transitions.

Basic Demographic Transition Model

The basic demographic transition model is depicted in Figure 1. During the premodern times (Stage One) both fertility and mortality rates are high and fluctuating. In the second stage mortality rates begin to decline while fertility rates remain high. Stage Three is marked with declines in both mortality and fertility, and in the last stage both mortality and fertility rates are low.

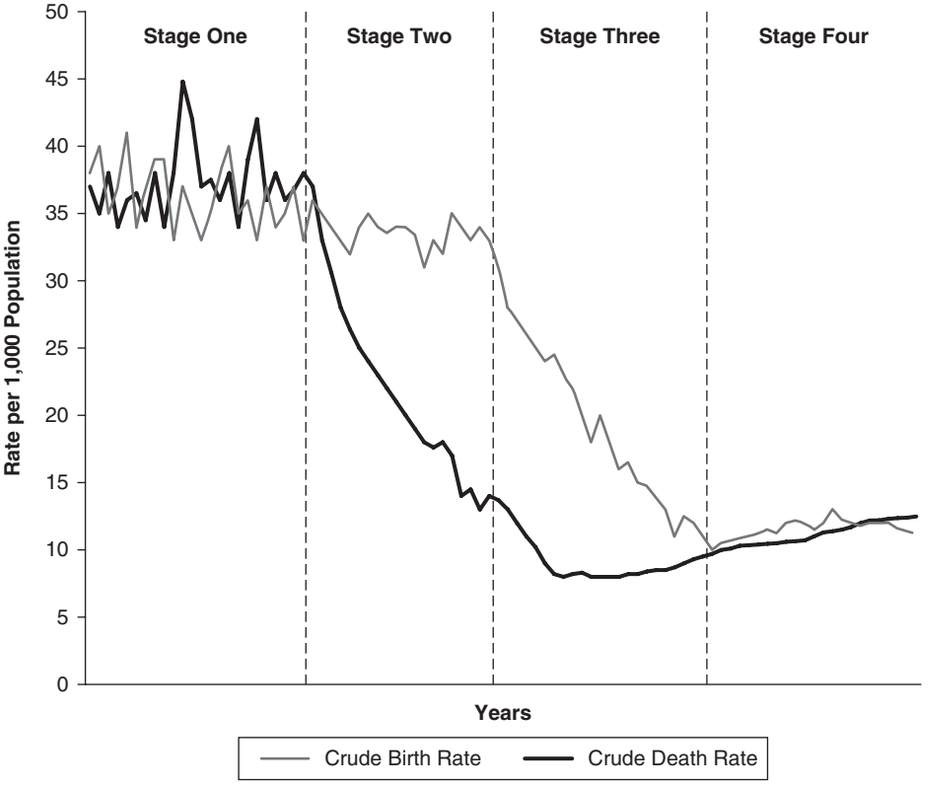

Figure 1 Demographic Transition Model

The demographic transition model was initially based on changes that occurred in Western European societies. For most countries large and irreversible declines in death rates occurred first, followed by declines in birth rates. No two countries have followed the same transition due to varied differences in patterns of marriage, fertility, and mortality, as well as differing cultural norms and values, at each stage. In Western Europe the mortality decline lasted from the latter part of the 18th century through the first half of the 19th century, whereas in less developed countries it began in the 20th century. The duration of the transition has also varied widely. The transition in Western Europe occurred over 75 to 100 years; in Eastern Europe, 20 to 25 years; and an even shorter period for those countries moving through the transition in the 20th century. In non-Western nations a decline in mortality has always preceded the decline in fertility. Indeed all countries that have gone through modernization have also experienced the demographic transition, and it has occurred under vastly different socioeconomic conditions.

Epidemiologic Transition Theory

The epidemic transition theory focuses on changes in the complex patterns of disease and mortality. Omran, the author of this theory, believed that demographic transition models overemphasized the role of fertility in population dynamics. His rationale was that in premodern societies the range of natural fertility is limited, based on the survival of women to reproductive ages, marriage patterns, and contraceptive practices, whereas the death rate could have no upper limit.

The focus of the epidemiologic transition is on shifts in disease patterns and causes of death, and the resultant impacts on life expectation. There are three basic stages in the epidemiologic transition: (1) the age of pestilence and famine, (2) the age of receding pandemics, and (3) the age of degenerative and "man-made" diseases.

The age of pestilence and famine was considered an extension of the premodern pattern of health and disease. In European societies this stage extended until the middle of the 18th century, and for less developed countries it has extended into the 20th century. Unpredictable and essentially uncontrollable major causes of death include epidemics, famines, and war. Other causes of death include parasitic and contagious diseases and malnutrition effects for children and tuberculosis, puerperal infection, and malnutrition effects for females. Infant and child mortality is very high with one third of the total population deaths occurring among children between the ages of 0 and 5 years. Females in adolescent and reproductive years have a higher risk of dying than do males in these ages because females are more vulnerable to infectious disease and also die due to complications associated with childbirth. In the age of pestilence and famine, average life expectancy at birth is variable and ranges from 20 to 40 years.

The early phase of the age of receding pandemics is characterized by fewer peaks and fluctuations in death rates, although mortality rates continue to be high. Infant and child death rates remain elevated, as well as deaths of females in adolescent and childbearing ages. As this stage progresses, improvements are first gained in maternal and adolescent mortality for females. Later infant and child mortality rates fall, in part due to increased health of females in childbearing ages. Life expectancy at birth steadily increases from 20 to 55 years.

The third stage reflects further reduction in death rates; thus more persons are surviving, especially to advanced older ages. Mortality rates steadily decline to below 20 per 1,000 members of the population. Child mortality accounts for less than 10% of the total deaths, and 70% of total deaths are to persons over the age of 50. Life expectancy at birth continues to increase to beyond age 70. Causes of death shift to chronic and degenerative diseases of old age as well as man-made deaths such as those due to environmental pollution, motor vehicle accidents, occupational hazards, and industrial accidents.

Population Effects of the Demographic and Epidemiologic Transition

During the early stage of the transition, both birth and death rates remain high. Many babies are born, but there are also many deaths from infancy through childhood and adulthood. There is little population growth during this premodern period because there is little difference between rates of births, which add to the population, and rates of death, which subtract from the population. In

most societies moving through the transition, death rates begin to decline while birth rates remain high. Thus, fewer people are subtracted from the population, compared to the persons that are added through births, so populations begin to increase in size. As birth rates begin to fall, the death rates are falling at a faster rate, so populations continue to grow. In the modern stage both birth and death rates become quite low and population growth slows, but population size is large due to the growth during the previous stages.

Accompanying the shift from high to low levels of fertility and mortality are changes in population age structures. With the declines in births and deaths in the latter part of the transition, there is the occurrence of population aging. This takes place when the age composition changes such that the older population increases its proportion relative to the total population and the proportion of young persons shows a concomitant decline. Linked with declines in death rates are improved survival chances, so more persons reach old age and total life expectancy increases.

The transition is seen as favoring the young, with greater survival rates, and also favoring females over males. Survival chances increase markedly for females through their childbearing ages such that by the last transition stage, females' age-specific death rates are lower than males for all ages. During the early stages of the transition, the sex ratio (i.e., the number of females per 100 males) indicates an excess of males. By the end of the transition, the sex ratio shifts with fewer males than females, particularly at older ages.

Causes of Declines in Mortality and Fertility Rates

Because the decline in death rates and birth rates were and are significant, considerable research has been conducted to ascertain the causal factors associated with the demographic and epidemiologic transition. The transition has occurred under diverse social and economic conditions. Theories regarding the declines in death rates have focused on a number of causal factors, which are discussed in this section. Specifically, much of the research on the demographic transition has focused on the vexing problem of explaining the fertility decline that typically followed the decline in mortality.

Mortality Transition

The decline in mortality through the transition has been linked with a number of causal factors. Death rates for premodern societies fluctuated because of unpredictable and essentially uncontrollable Malthusian positive checks of epidemics, famines, and war. There exists no unique cause or factor that affected all mortality declines. Because societies were experiencing declines in mortality in different centuries, the causal factors for the transitions differ as well. A combination of public health efforts, nutrition and diet, personal hygiene, current technologies in science and medicine, current understanding of etiology of diseases and illnesses, and a population's standard of living have had effects on the transition in death rates over time.

Improvements in agriculture and food production led to more stable and varied diets. One result was a reduction in deaths due to famine. Better nutrition also aids the body in fighting and surviving infectious and contagious diseases. Women in childbearing ages were healthier, and thus, were able to survive pregnancies and produce healthier babies.

Many municipal and public health efforts have led to declines in death rates. The establishment of stable governing bodies reduced deaths due to violence and civil wars between tribes, ethnic groups, or opposing factions. Governing bodies also reduced death rates through legislation such as the enforcement of quarantining of ships that might bring diseased immigrants to new environments such as the United States. Laws were also enacted to quarantine sick persons to their homes or to "pest houses" to isolate them from the rest of the population. The development of public works programs, such as cleaning streets of filth and, later, the introduction of piped clean water and sewer systems, served to reduce death rates in urban areas.

Increased knowledge about the causes and treatment of infectious and contagious diseases, such as inoculation for smallpox in colonial America, and vaccination for other diseases in the 19th and 20th centuries has reduced epidemics through time. Scientific and medical advances, such as germ theory by Louis Pasteur in the 1860s and the study of bacteria by Robert Koch in the 1890s, led to a greater influence of medical knowledge and practice on death rates in the 20th century. Medical research and discoveries continued

throughout the 20th century, such as the discovery of penicillin in 1943 and other antibiotics, which greatly affect the transitions in mortality decline in non-Western countries.

Fertility Transition

It should be noted that premodern fertility rates varied among countries due to differences in the age at first marriage, the proportion of childbearing women who were married or living in a union, norms and practices regarding nonmarital fertility and childbearing, differences in breastfeeding practices, and other norms regarding sexual intercourse. Thus there were large variations in natural fertility, or the number of births to women who were not consciously trying to reduce births.

Social and cultural factors contributed to changes in Western European fertility. The marriage patterns changed to later ages for marriages and high proportions of females who remained single. The spread of fertility decline was quite rapid in Europe in that, excluding France (whose fertility decline started much earlier), 59% of the fertility decline occurred between 1890 and 1920. The cultural diffusion of knowledge and norms regarding fertility behavior has been noted due to similarities in fertility patterns among contiguous groups sharing a common language, religion, or ethnicity. There also were ideational changes that accompanied the decline in fertility, including a move toward secularization, greater egalitarianism, and individualism within the family as the result of a shift from extended to nuclear families and the change in the status of women. Decisions regarding childbearing (e.g., timing and number of children) shifted from the community to individuals within a marriage. The introduction of formal education, particularly for girls, and increasing employment opportunities for women have reduced fertility rates by postponing age at marriage and the timing of first births.

Economic factors, alone and in concert with social factors, also came into play. Age at marriage was, in part, determined by when a couple had the economic resources to establish an independent household. The value of children changed such that children switched from being assets to expenses, thus the rational decision would be to reduce the number of children produced. In premodern societies children contributed to the family with work, money, and other resources. With modernization, change in place and type of work (from agriculture to industry), and the development of more formal education, children become expenses.

Birth control techniques did not have a great effect on the change in Western European fertility. Most contraceptive methods, except modern chemically based methods such as the pill, have been around since ancient times, although the knowledge was sparse and unsystematic. However, in the 20th century the introduction of effective family planning programs in developing countries resulted in fertility decline regardless of the country's level of modernization. Once there are increases in the number of couples practicing family planning and fertility control, marital fertility declines and the trend becomes irreversible. Fertility decline has now been observed in all regions of the world.

Future Stages of the Demographic and Epidemiologic Transition

The demographic and epidemiologic transition models have assumed that there would be a stabilization of low birth and death rates at the end of the transition. Instead, birth rates in most European countries have dropped below replacement-level fertility, which is 2.1 children born per woman, and life expectancy has continued to increase.

A second demographic transition model has been developed to characterize the changes in Europe and Japan regarding household structures, fertility, and marriage patterns, which have occurred in the last third of the 20th century and into the 21st century. The trend is characterized by the further postponement of marriage, an increase in cohabitation, delayed childbearing, out-of-wedlock childbearing, a rise in divorce and separation rates, and increased single-parent families. Household size has decreased, and there are more adults living alone. Causal factors for such changes include the shift from an emphasis on physical and economic security to an emphasis on self-expression, self-fulfillment, and quality of life. This has led to total fertility rates for women to be around 1.5 or less. There are major concerns regarding the size and composition of populations given the reduction of births.

The United States has followed trends of cohabitation and marriage and fertility postponement

similar to those of Europe; however, fertility rates have not fallen far below replacement levels. One explanation is the heterogeneity of the population, in part due to immigration of persons from countries with a culture of higher fertility levels. There also is heterogeneity across regions of the United States regarding patterns of cohabitation and the timing of marriage and first births. However, studies show that the United States is following the second demographic transition model and that fertility will also decline in the future.

Death rates have declined further than initially imagined by the epidemiologic transition theory. Improvements in life expectancy at birth were expected to slow after reaching 70 years, and declines in mortality rates were expected to come to a halt or be reversed. Instead, total life expectancy has continued to increase into the 80s for a number of countries, including Japan, Singapore, Sweden, and Switzerland.

There have been suggestions that an additional stage should be added to reflect increased rates of survival throughout the 20th and into the 21st century, particularly for older persons. Deaths due to chronic conditions, such as heart disease, have declined at a greater rate than first imagined. Models of a new stage in the epidemiologic transition primarily emphasize that causes of death complicated by social and cultural factors will dominate. Lifestyle behaviors such as smoking, diet, and exercise will have an important influence on mortality rates. But the patterns of lifestyle behavior are not uniform across countries, and thus, patterns of mortality may differ as well.

Another influence in the new stage of mortality rates is the emergence of more deadly infectious diseases, such as HIV/AIDS, SARS (severe acute respiratory syndrome), Ebola virus, and avian (bird) flu. The 20th century witnessed a decline in deaths due to infectious diseases, but these new viruses are more difficult to identify and control. In addition, more drug-resistant strains of infectious diseases, such as tuberculosis and malaria, are emerging.

One final factor that will also affect death rates is population aging, which is a worldwide phenomenon. The proportion of older persons is increasing due to both lower birth rates and longer life expectancy. Populations will reach a point in which death rates will increase because more of the population will be in the older age brackets, which carry the greatest risk of dying.

Vicki L. Lamb

See also Causes of Death, Historical Perspectives; Gender and Death; Life Expectancy; Malthusian Theory of Population Growth; Mortality Rates, Global

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Denial of Death

Visiting a rural cemetery that contains 18th- or 19th-century tombstones reminds us of the then high mortality rates of infants and children. Before the advent of hospitalization of the sick and dying, death was a normal part of family life. Birth and death were realities seen in every household, both among farm animals and people. Death was an important event in the life of a family, but it happened frequently enough that it was seen as something that happens to everyone, not as a significant catastrophe. Philippe Ariès suggests that death simply reflected a normative life span experience, in his words, a collective notion of destiny. As humanity lived through the Industrial Revolution, urbanization, globalization through two world wars, the isolation of nuclear family mobility, and

the medicalization of all maladies, there has been an increase in anxiety and angst around the end of life. Young people are increasingly removed from any exposure to, or experience with, the elderly and the end of life. Death is viewed as an inconvenient enemy. Particularly in the 20th century, denial as the dominant coping response became common. Ariès traces this new attitude as having begun in the United States and since spread to Europe and all of Western culture. Today, the denial of death is frequently linked with youth-oriented culture, but this reflects only one perspective of the denial of death. The denial of death can be understood as a cultural phenomenon, a personal coping strategy, and also a life span issue. From these three vantage points this entry takes on different issues.

Cultural Phenomenon

The death-denying attitude in American culture became pervasive during the latter half of the 20th century. In the early 1900s, most deaths occurred at home, as the result of accident, trauma, or acute infection. One hundred years later, most deaths occur in hospitals and skilled nursing facilities, as a result of long-term chronic conditions including heart disease, cancer, and dementias. Medical breakthroughs in diagnosis, technology, and biological agents, including antibiotics, have revolutionized medical care and reinforced the myth that death can be defeated. In the *Experience of Dying,* E. Mansell Pattison notes that the care of persons who are dying has been handed over to physicians and hospitals. However, when surveyed, physicians are more likely to be more uncomfortable around death than are most other health care professionals, seeing it as a failure in their expertise rather than a natural part of life. The denial of death is seen in medical settings when staff avoid the dying patient or adopt a not-on-my-shift mentality. Care is relegated to the intensive care unit where the family is marginalized and the dependence on technology is reinforced. Most health care dollars are spent in the last 6 months of life. Death is understood to be giving up or failing rather than completing the life course. It is seen even more dramatically in long-term care facilities, when the death of a patient is noted only by the removal of personal things and an empty bed. Returning to work and finding one's patient has died and the bed has already been filled by another resident is a common experience for nursing home staff. One nursing home had an old elevator at the back of the building that was too old to be used by residents, but because it went directly to an area near the back door, it was used to move bodies so that they could be picked up by a funeral home. The noise of this old elevator was the only sign to the residents that someone had died. The denial of death has, at times, resulted in institutions either not wanting to offend or wanting to protect residents and staff from grief. However, by denying death, a new form of fear is created, the fear that one will die and no one will notice.

Personal Coping Strategy

Since the publication in 1969 of Elisabeth Kübler-Ross's seminal work on anticipatory grief, the field of thanatology has seen a proliferation of models of grieving. Most include at least some adaptation of the Kübler-Ross stages of grief model beginning with denial. Authors and practitioners recognize that a common response to loss is the attempt to maintain homeostasis through rejection of the scope of change. Even William Worden's theoretical framework around the tasks of grieving focuses first on the importance of accepting the reality of the loss, in response to the assumption that failure to accept the reality of the loss is the normal first response. Unfortunately, some writers in the area of death and grief and many consumers of medical care and bereavement services have written about this denial of the reality of the loss as pathological or negative. In reality, it is normative and protective, unless taken to an extreme. Similar to any other defense mechanism, survivors' denial of death can protect them from experiencing too much reality too quickly. Like a car airbag that activates when the car is hit, denial cushions survivors from the full impact of their loss. This protection allows survivors to negotiate complex societal requirements in a time of crisis while maintaining some homeostasis. Like any other phenomenon of health, denial in moderation is a healthy mechanism. Denial that persists for months, that does not respond to the work of grief, or that becomes increasingly

delusional requires professional intervention. However, practitioners must be very careful not to overpathologize this phenomenon. The mind is able to recall shared experiences with enough power and reality to respond physiologically. So, the common experience of seeing or hearing the deceased in the immediate days and weeks after the death is rarely indicative of psychosis and should initially be normalized as much as possible.

Developmental or Life Span Issue

The experience of death denial in children and adolescents is a developmental phenomenon, particularly in industrialized countries where medical advances have increased life expectancy and changed the death experience, from acute to chronic illness and from home to institution. Children and adolescents are rarely exposed to end-of-life issues, in part because nuclear families are disconnected geographically and experientially from older family members. Many children and adolescents have never visited a hospital or nursing home; nor have they experienced the death of anyone close to them. Their exposure to death occurs through television and movies in which the person who died might be on another show the following day or week. These experiences reinforce the natural developmental belief that children and adolescents are invincible.

For children younger than 3 years of age, there is very little knowledge of death. Infants respond to the emotion and grief of significant adults around them. As they develop object permanence, they respond to the absence of love objects but do not conceptually understand death. From 3 to about 5, children have a difficult time understanding death as they are not cognitively able to process the construct of death as the ending of life. They understand such concrete issues as broken or out of reach, but in either case, it is the obligation of the parent to fix the situation. Sigmund Freud understood this to be a part of the development of the permanence of the objects around the child. Latency-age children and preadolescents begin to understand the permanence, universality, and irreversibility of death but resist the notion that death is something that can happen to them. This attitude deepens and intensifies in adolescents and young adults, whose engagement in high-risk behaviors is often a reflection of a belief that they are invulnerable. This death denial has been credited with increases in high-risk sexual behavior in an era of HIV and AIDS; high-risk, mind-altering drug use; and, interestingly, with valor in military combat.

In the lengthening middle years of the life cycle, the experience of death denial is manifested in a variety of ways, from the myriad euphemisms used for death to the relatively new phenomena of cryonics. Conversations about death and dying are softened by the use of words like asleep and passed away. Before burial, bodies are first prepared with makeup to look normal and positioned to appear asleep in caskets that, in part, are marketed by the comfort of their mattresses. In the growing phenomenon of cryonics, bodies are frozen for preservation and awakening at a time when the cause of death can be reversed.

At the other end of the life cycle, studies of older adults have consistently found that seniors are less likely to be afraid of death and more likely to be afraid of how they will die. Fears of suffering, of intractable pain, and of meaningless and purposeless days are the focus of many older adults. The process of dying is significantly more terrifying than the actual prospect of death itself. Victor Cicirelli points out that there is a distinction between body loss as a physical entity and mental or spiritual loss as emotional and spiritual entities. The prospect of body loss, which is another way of referring to how the body will be lost, can be terrifying to older adults. However, the prospect of mental or spiritual death may not be as worrisome. It is not unusual for older adults to engage in denial of death to protect their children and grandchildren from an emotionally upsetting topic and protect themselves from a difficult discussion.

This life span perspective suggests that the denial of death, a common phenomenon, is experienced differently in the various development stages. For young children, death denial is related to their inability to grasp the concept of the permanence of death. At such time as the child can comprehend abstracts such as permanent loss, then a denial of death that stems from a complete fear of death may develop. This is seen both in adolescents, who cope by believing themselves to be invulnerable, to middle-aged adults, who fear the interruption of death. This denial continues until old age, when in another transition, the older adult

moves from being afraid of death to being afraid of how they will die.

Conclusion

In summary, the denial of death can be understood as a cultural phenomenon, a personal coping strategy, and a life span issue. Like other social sciences, modern thanatology has rejected the singular concept of denial of death. Denial of death is ingrained in the elements of our modern society, in which physicians view death as a failure of their art. Additionally, when seen as a step in the process of coping, denial of death is a transient stage, something to pass through, not a permanent part of the human landscape. When viewed through the lens of human development, denial of death is an evolving experience based both on cognitive capacity and interrelational dynamics. Practitioners need to examine the evidence based on how the client sees death to determine how each of these three perspectives will be most useful. Essential to practitioners is the understanding that denial of death is pathological only when exaggerated beyond the norm of coping mechanism and beyond the scope of therapeutic support.

James W. Ellor and Helen Harris

See also Aging, the Elderly, and Death; Awareness of Death in Open and Closed Contexts; Childhood, Children, and Death; Death Anxiety

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Depictions of Death in Art Form

Death has been a topic of depiction as every culture develops a way of representing the deceased. As this topic concerns representations of death in art form, it is most illustrative to focus on Western culture where an established definition of art exists and is influenced by the social and religious environment. In this view the relationships between the human experience of death in social context and their expressions in art form can be observed.

This entry describes the primary methods used to depict death throughout the centuries. These different approaches are considered within a global perspective consisting of establishing the links between this practice, social change, and the permanence of religious conceptions.

Different Means of Representation of the Dead

Two distinctions of the representations of the dead can be offered: the *ad vivum* (prior to death) depictions and the *postmortem* (after death) depictions. However, each representation may be viewed in the same Christian conception of death.

During Renaissance England and France, the tradition of the king's double corpse appeared: the real one, putrescible, and the other, immortal effigy. Clémence Raynaud indicates this was made by artists who used a mortuary mask, made from a postmortem molding of the king's face. Use of this effigy was determined by political events and social need. As one example, it had to symbolize the permanence of the king's life and the continuity of the political body during the transmission of power. This ritual of transmission could last several weeks, and the effigy was used in order to avoid any semblance of a hiatus in power.

During the Renaissance the fashion of recumbent effigies, which adorned the graves of royal and aristocratic families, also appeared. These effigies were a faithful representation of the dead, generally portrayed in a state of sleep, thus creating the illusion of restful death. These figures also were represented with opened eyes, thus symbolizing the living. The position of the effigy with joined hands was suggestive of prayer, thereby attesting to the religiosity of the deceased.

At the end of the 14th century, a new recumbent effigy, the *transi*, represented the deceased in a state of decomposition. This fashion is linked with the development of the dance of death (*danse macabre*) theme, inspired by the occurrence of great epidemics and used by the church to influence the population through spreading ideas that led to the fear of death.

About this same period another depiction of the dead appeared in Poland: the coffin portrait, a hexagonal shaped portrait fixed on the side of the coffin. Representing an idealized image, this portrait was a way to identify the deceased physically and socially, especially among aristocratic families. Przemysław Mrozowski indicates this portrait, as an ad vivum depiction, was intended to display death not as the end of life but as a transition from one state to another. Thus, the coffin as an element of the liturgical ceremony became representative of the permanence of life beyond biological death.

A new form of funeral portrait first appeared among the Flemish bourgeoisie during the 16th century as well as in France, England, and the United States. As Emmanuelle Héran explains, when a family member was lost, a painter was asked to depict the dead in his or her bed. Such portraits can be considered expressions of *ars moriendi*. Indeed, they are depicted after the fashion of those representations of the deaths of Jesus Christ, the Virgin Mary, and the saints. Philippe de Champaigne played a prominent part in the diffusion of this Flemish practice in France, especially among the partisans of Port Royal. Funeral portraits were initially public but became progressively integrated into private areas.

From this practice emerged another art form, namely, the mortuary mask. Philippe de Champaigne, in responding to a request of the partisans of Port Royal, depicted postmortem portraits and, in so doing, he used a mortuary mask of the deceased as a template for paintings. The mask of Blaise Pascal, who died in 1662, was made for this purpose. In the 18th century, France, Germany, and England also began to use this technique, not as a template but as a representation of the deceased. This method was completely integrated in the 19th century to be followed by Italy, Russia, and the United States. Thus, we can find mortuary masks of Dante, Puccini, and Tolstoy, among other great characters. In France, the famous Madame Tussaud made masks of Marat and Robespierre, but it was in Germany that the production was most important. Among the gentry the practice spread to the artists and intellectuals such as Goethe, Beethoven, and

Recumbent effigy of the Queen Jadwiga in Wawel Castel

Source: Emilie Jaworski.

Lessing as well as political leaders including Frederick II of Prussia. Even if the practices of mortuary masks and postmortem paintings were simultaneously in use during this time, the mask had a great advantage in that it was infinitely reproducible and easily transported.

In the context of democratization of postmortem portraits, photography was used as a new medium for the depiction of the dead. Considered to be a faithful reproduction of reality, initially the pictures were used by painters as models but, progressively, they became a new way of making funeral portraits. Bourdieu noted the success of photographic method functions, as with other representations of the dead, to solemnize and eternalize the great moments of collective life. Furthermore, this method had a lot of advantages compared to the effigies, statues, paintings, and masks. It was possible to make portraits more realistic and much more quickly, and the pictures were infinitely reproducible and easily transported. The success of this practice also resulted in cost reduction. Indeed, everybody could afford such portraits. However, it cannot be concluded that postmortem pictures were used only by common people. Indeed, postmortem pictures of famous people such as Victor Hugo, Marcel Proust, or Gustave Doré also are known to have been created by Nadar and Man Ray, whereas portraits of common people were made by anonymous photographers. If the former stayed in a formal artistic way of making portraits, the latter developed as a kind of popular art.

Social Context of Representations of Death

The progression of the funeral portrait was determined by its democratization. Previously reserved for the saints and then for kings and aristocrats, its use was extended to bourgeois families and to great national figures. This democratization and personalization of the postmortem portrait reflects the transformation of Western societies. The development of the bourgeoisie and then the French Revolution shaped new political and social ideals, allowing the appearance of egalitarian values and of individualism to become an important part of the cultural ethos.

To understand the success of the funeral portrait, it is necessary to focus on the relations of those societies with death. In France, cemeteries were completely integrated into social life until the 17th century when the Church forbid what was then called "unholy behaviors." Even as the French Revolution implied a change in the perception of death, funeral portraits were still in use. Indeed, the increased importance of hygiene and sanitation, along with a declining importance of religion, led to the relocation of cemeteries outside of city boundaries.

This distancing from the reality of death was temporary, and the pomp of the ancient regime reappeared during the 19th century. Grief became a social event that focused on the deceased's bedroom. People became accustomed to the reality of death, and it was usual to visit the Paris catacombs or the public mortuary as a form of entertainment. In this context, death was an everyday reality, which could even appear as a show. Proximity to the dying and the dead lends some understanding of the motivation of people to order such portraits. This event caused community members to gather around a deceased person, who embodied the social essence of ars moriendi (the art of dying a good death) and thus ensuring one's eternal salvation. In addition to the social context, the traditional depiction of the dead was characterized by the Christian conception and practice. Indeed, the tradition of making portraits of the dead was inscribed in the continuity of religious portraits of the saints and of Christ. When the living representations of the dead suggested the permanence of life after the occurrence of death, the postmortem representations were expressions of the ars moriendi as determined by the concepts of judgment, heaven, and hell. These supported the pastoral play based on the fear of death. Furthermore, the Christian concept of the individual offers a more complete explanation of the tradition of depiction of the dead. Accordingly, the soul and the body are the components of individuality, even if a distinction is made between them. Indeed, the soul has to master and transcend the body, which is considered the

source of sins. After death the body is disintegrated and the soul is supposed to stay alive until the Last Judgment when believers will resuscitate. Even if the concept of resurrection is considered as a metaphor, Christian death does not imply a dispersion of the components of individuality but a reunification in another dimension. Thus, the body stays an important reference in the definition of the individual during one's life and after death. So the depiction of the dead underscores not only the permanence of life but also the permanence of individuals among the living.

Emilie Jaworski

See also Art of Dying, The (*Ars Moriendi*); Dance of Death (*Danse Macabre*); Death Mask; Depictions of Death in Sculpture and Architecture; Funerals; Photography of the Dead; Soul

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Depictions of Death in Sculpture and Architecture

The depiction of death as both a physical reality and as an abstract concept has been a preoccupation of sculptors, builders, and architects for centuries, particularly in relation to gravesites and funerary monuments. Since ancient times nearly all cultures have developed rituals and beliefs surrounding the death of a person. In Western civilization death has often been personified in art. Other ways of depicting death range from allegorical figures (a human figure that represents or embodies an abstract concept such as hope or faith) to representations of the dead body. In architecture, certain types of structures and monuments, whether at gravesites or, for important or significant people, in public spaces, have also developed into a visual "language" of death. Much of what we know today about the way people have thought about or considered death in the past comes from the study of funerary and commemorative art and architecture.

Depiction in the Ancient World

In ancient Greece, death and life became personified—that is, ascribed a human figure and personality. Life was considered as feminine, and death as masculine. In classical Greek mythology, the minor god Thanatos was the personification of death and mortality. Thanatos was the twin brother of Hypnos, or sleep. The twins were the sons of Nyx (night) and Erebos (darkness). In ancient Greek sculpture Thanatos was often shown as a winged youth (or angel), often with his twin, as a mediator between two gods negotiating for a mortal soul, or at the scene of a death (e.g., a battle scene). Thanatos was not seen as a fearful or tragic figure; rather, Thanatos (from which the word *euthanasia* is derived) was often depicted as a peaceful, serene presence. Thanatos's presence on a sculpture did not imply that the work was necessarily a funerary monument. The Greek tradition of death as a winged figure, and one often synonymous with eternal sleep, is one that influenced many later artistic representations of death. Later, in European depictions of Thanatos, he is

often shown holding a downturned or extinguished torch, symbolic of a life that had ended. Ancient Romans did not produce specific sculpture depicting representations of death, although these occasionally appeared in mosaics and other artistic forms.

Architecture and tomb structures related to death in the ancient world came in many different forms and sizes. It is important to note that death-related architecture never depicted death in the same way that sculpture did, but acted more as an indication that they were connected to, or housed, the deceased. Some structures were meant to accommodate individuals, others for large numbers of persons, for example, multiple generations of a family. In general, the large monuments and structures that have survived were almost always erected for rulers or powerful persons. Pyramids—such as the famous ones at Giza—are the most recognizable and enduring form of ancient Egyptian architecture; they mark the resting place of the pharaoh, considered the embodiment of a God on earth. Pyramid tomb shapes were later used in ancient Greece and Rome. Temple structures were popularized in ancient Greece, while mausoleums—often in temple shapes—were popularized in ancient Rome. In the ancient Mideast, characteristic tomb and mosque shapes were rounded. Some Asian cultures favored pagoda-like structures. All of these cultures and countries, however, borrowed ideas from each other, and myriad variations can be found everywhere throughout history.

Medieval Period

The Middle Ages (ca. 500–1400 C.E.) were a particularly rich era in memorial arts. As Christianity spread and flourished during this period, the concept of *memento mori*—a term coined in ancient times—became dominant. Loosely translated from the Latin, the phrase means "as I am now, so too you shall be," referring to the fact that everyone must eventually die, regardless of wealth and status. Christian religion emphasized salvation of the soul through good deeds and living a pious life, so memento mori served a moralizing purpose.

Despite the leveling nature of death, status was still indicated by the size and quality of one's tomb (or lack of one). For those who could afford it, however, there were options. One was commissioning a stylized portrait figure engraved on a brass plate. Though not technically sculptural, making these required the skill of the engraver as well as the sculptor, two often interrelated skills.

Persons of higher status and wealth could commission full-length recumbent portrait figures of themselves atop or near their tombs. These are fully realized three-dimensional sculptures, often of a husband and wife lying or "sleeping" under an elaborate canopy, occasionally with other references to their earthly lives—such as the inclusion of a pet dog—as part of the scene. These recumbent figures usually express serenity and confidence that through their pious lives, their souls' salvation has been assured. An example of this type of sculpture is the pair of recumbent figures of Charles III, King of Navarre (d. 1425) and his wife Eleanora of Castille (d. 1416) in Navarre, Spain.

A particularly stark type of monumental sculpture was the "cadaver tombs" that were popular for those who could afford them. These were popular especially in England, Italy, and France but were produced elsewhere in Europe as well. Only the high-ranking or very wealthy could afford to have these made, as they required expensive materials and highly skilled artists to produce. A cadaver tomb is a monument in which a full-length sculptural representation depicts the deceased either right after death or in some advanced state of decay. Emaciated corpses or skeletons, sometimes shown with the worms and other animals that would feed on the remains, were graphic and realistic depictions of the transience of life and earthly pleasures, and of the inevitability of death. These were also reminders that death would overlook no one and that there was a vast difference between dying a "good death," that is, being assured of salvation and an eternity in heaven, and a "bad death," one in which salvation was probably out of reach, therefore dooming the deceased to hell. Only a virtuously lived life could ensure the salvation of one's soul; presumably cadaver tombs also acted as motivators of the very real dangers and horrifying consequences of dying a "bad" death. Examples of well-known cadaver tombs include that of Cardinal Jean de Lagrange (d. 1402)

in Avignon, France, and of William Sylke (d. 1502) in Exeter, England.

Apart from Christian concepts of death, another major factor affecting depictions of death during the Middle Ages was the devastating effects of the plague. The plague, or black death, which ravaged Europe at various times between the late 14th and 17th centuries and in many cases decimated entire populations, also contributed to fearful depictions of rotting corpses, known as *transis* in art. Although plague victims were rarely depicted in sculpture, their representations in paintings and engravings of the time—for example, the dance of death images—had a significant impact on other visual arts.

The Renaissance

The Renaissance, a period of cultural, artistic, and architectural achievement that remains unmatched to this day, produced some of the finest sculpture ever known, by artists such as Michelangelo and Leonardo da Vinci. This was also a period during which artists emerged from the relative anonymity of the medieval guild system and began to cultivate their own patrons and sign their own works.

Artists who lived during the Renaissance (literally "rebirth") found renewed inspiration in themes from antiquity. In architecture and sculpture, church and tomb structures based on ancient Greek and Roman temples were the norm, while sculpture resurrected the realistic representation of the human body and the portrait bust, among other devices. Most sculpture commissions for Renaissance artists were funerary monuments. Depictions of death developed into a particularly rich variety of tomb sculpture. Since the wealthy were usually buried inside churches, large and elaborate interior monuments were the norm, especially if the family could not afford to build its own private chapel. Architecture to house the deceased was usually in the form of a church or, borrowing forms from antiquity, a temple or mausoleum.

Death as a skeleton or rotting corpse continued to influence generations of artists and sculptors; depictions of these popularized during the medieval era remained common, especially for wealthy or high-born clients. A newer, less frightening conception of the skeleton appeared at this time: the winged skeleton. Gian Lorenzo Bernini, one of the Renaissance era's most celebrated artists, designed many different funerary monuments, and his work was extremely influential. An example of Bernini's work is the Merenda monument in the Church of San Giuseppe alla Lungara (Rome), which shows a winged skeleton ascending while displaying a large rippling "banner" that contains all of the deceased's biographical information. Another Bernini-designed monument is the Vallini monument in the Church of San Lorenzo (Rome), which shows an ascending skeleton holding a cameo portrait of the deceased.

Monuments to deceased popes were important and highly visible. These, again designed by highly influential artists, often memorialized such men by showing them in full three-dimensional form, sometimes as they had appeared in life, for example, praying on their knees, but often on their deathbeds, much like the recumbent styles of the medieval period. Monuments dedicated to deceased popes were extremely elaborate, often reaching tremendous heights; for example, St. Peter's Basilica in Vatican City has a cavernous interior and extremely high ceilings. These monuments comprised many different parts and sculptures, often in differently colored marble and always exquisitely carved. Sometimes depictions of death were subtle, such as the recumbent figure; other times figures such as a skeleton holding an hourglass or participating in the dance of death, were more overt reminders of memento mori, the fact that even popes are mortal. Not all great artists called upon to design tombs for a pope chose such graphic representations, however—for his design of the tomb of Pope Julius II (1542–1545, Rome), Michelangelo chose the mythological figure of Moses from antiquity to symbolize the power of the pope. Other popular topics for tomb sculpture included angels, saints, and the Virgin Mary.

Beyond the Renaissance

Since the Renaissance, depictions of death in Western sculpture and architecture have primarily relied on motifs and representations popularized throughout history. In colonial America, Puritans

used variations of memento mori iconography, such as skeletons with scythes (i.e., the Grim Reaper), skulls and winged hourglasses, all on slate gravestones, to ensure that observers understood that time would not stand still for anyone. By the late 18th century, however, depictions of death—now mostly in white marble, a new material in America but long favored in Europe—took a very different turn, emphasizing a more hopeful spirituality and a collective belief that every individual could ascend to heaven. Depictions of skulls and skeletons lessened in favor of a wide variety of motifs, including sleeping babies, cherubs and angels, and botanical motifs. Classical motifs such as downturned torches, funerary urns, and mourning allegorical figures were also popular, particularly in 18th- and 19th-century Europe and 19th-century America. Architectural structures to house the deceased still borrowed from antiquity, most notably in the forms of mausoleums, often designed to look like miniature Greek temples or churches.

Since the 19th century in Europe and America, graphic depictions of death in sculpture have virtually disappeared. In cemeteries, granite stones with generally pleasing motifs have replaced earlier, more elaborately carved slates and marbles. Contemporary works of art—most notably, Damien Hirst's controversial "For the Love of God" (2007), a platinum cast of a human skull (with real teeth) encrusted with over 8,600 diamonds—occasionally use death or memento mori imagery, but usually for publicity or shock value. In general, depictions of death today in art are uncommon.

Elise Madeleine Ciregna

See also Depictions of Death in Art Form; Memorials; Monuments; Symbols of Death and *Memento Mori*; Tombs and Mausoleums

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Depictions of Death in Television and the Movies

While television and cinematic film are well recognized as the medium with the greatest communication impact across the globe, only recently have the various forms of death depicted in these formats received serious consideration. Because death is no longer a taken-for-granted finality to life, it has become a focus of considerable research and debate. This developing field proffers an understanding that death is not only the underlying driving force in nearly all cinematic narratives or television genres, but its various forms and portrayals are a psychological response to a deep-seated human need to confront the concept and inevitability of death.

Interaction with movies and television is a viewing experience that is much more complex than simply watching for enjoyment. These visual texts "talk" about issues of identity at both a personal and a social level. It is the act of viewing that most fully provides a candid experience in regard to how people come to grips with the concept of the finality of identity through death as well as the related fear of abandonment.

It is the concept of death as portrayed in both the large- and small-screen experience that has assumed an important point of reflection and social comment. Sociologists tell us that the current number one fear across the globe is related to our inability to articulate our understanding of existence. In other words we experience some difficulty in answering the philosophical questions of who or what we are, and how we will end up. The concept of death is important to this understanding because to answer questions relating to life and death, it is critical to achieve some understanding of the concept that defines our end.

Visual experience plays an important function by providing an ending and by revealing myriad forms that deal with death as the ultimate finality and the finality of earthly existence. From the very first movies that dealt with the death of the Christian messiah to the 21st-century cinematic and televisual themes of the undead, the living dead, murder, suicide, and the concept of a good death, a consistent theme in this viewing experience is that death is both an ongoing source of fear and fascination.

Although no single media definition of death can sufficiently capture the full meaning of cultural mores, myths, and metaphors that reveal our relationship to death, death often is characterized by visual metaphors. The most common of these is the Grim Reaper, the dark, hooded, unknown, menacing being. This visual metaphor represents the ultimate threat to human existence and that point of life beyond which there is no comprehensive understanding. In the following sections we deal with the concept of death by a discussion of the organizers of menace.

The Death of Individual Identity

One's reflections on philosophical questions relating to self within the context of everyday life underscores the self-awareness and knowledge that life is finite and that answers to existential questions of self may remain unanswered. Some analysts recognize that this fear of death becomes crystallized in the consciousness around the age of 3 years. The reality of death as the ultimate form of the unknown is a constant throughout life. As such, our television and movie viewing experiences allow us to see, firsthand from an early age, actual corpses. These physical aspects of death have always been seen as a typical source of abject fear in that the corpse is reminiscent of life. The physical nature of the corpse reinforces the possibility that life is simply mayhem that leads to total abandonment.

Whereas movies from the 1990s, such as *Philadelphia, The Sixth Sense,* and *City of Angels*, offered elements of hope with regard to death, more recent movies have returned to a more pessimistic perspective reflecting the uncertainty the concept of death of the individual brings. These themes of insecurity are epitomized in the movie *The Departed* (2006), wherein the death of those seeking to engage in fighting corruption and crime are cast in similar forms of capricious finality as those who are selfishly destroying all in their path for self-gratification. The final metaphoric scene with a rat in the foreground of the Massachusetts State Legislature gives voice to the futility of making sense of an individual life given the inevitability of death.

Just as the human condition is haunted by this fear and the apparent inability to find a suitable answer as to the nature of self, so it becomes a more concrete visualized image on the screen, through ongoing representations and iterations such as the slasher films, *Frankenstein* motifs, and Dracula forms. The Count and his vampyric minions are at the same time both alive and dead, thus placing themselves outside of the natural realm and apparent cycle of existence that is unknown.

The fascination-with-death motif deals not only with fear but with the fascination with death itself. The entire host of the cinematic and televisual death scenes, from the living dead and zombies to the fascination with Egyptian mummies, not only serves as a threat to humanity but also reveals the obsession with the fears related to the transformative process of death. Through observing these "death transformed" creatures, it is possible to comprehend the prospect that death is a developmental process that involves physical transformation.

In real life we experience a single point of death, but with movies another sense of menace is revealed, namely, decomposition. Although many forms of death occur in film and video narratives, it is only the zombie, mummy, and Dracula motifs that explore our fear of what happens to the body after death. And it is through the horror films that this degeneration process is visually explored. Bandages, bites, and blood mark the corpse as being in the process of degeneration, which is the first form of the radical trajectory that occurs after death.

Death as Social Disconnection

The process of death also involves the severing or disassociation of a supportive psychosocial network. Thus, the forms and points of death as portrayed in the movies are often couched as the disengagement of an individual's social and cultural identity.

Death of the central characters in the multimedia experience is rarely defined or revealed on an individual level. Instead it is typically connected to a context involving friends, loved ones, family, societal connections, and a broader cultural fabric. With the exception of horror films, scapegoat themes, and elements of suicide, overwhelmingly individuals resist death in the movies and television. Thus, by its very participatory nature, the visual narrative not only allows the viewers to revisit the notion of death as physical and psychological disconnection from the here and now but also provides an opportunity to revisit this disconnection point within the framework of societal and cultural immersion. The movie *Babel* touches on the all of these issues as well as from different cultural standpoints through the use of a pastiche of intertwined vignettes. Although the differences in death are briefly touched on in this movie, the connecting thread is the notion that the most powerful disconnecting force death brings is the severing of our social familial fabric and our fear of being alone in this world and in death.

The experience in a darkened movie theater has been compared to a "dream-like" state which, in the case of death portrayals, provides the viewer with an even more reflective opportunity to begin to allow both personal desires and subconscious fears to surface. The viewing of death and all the facets of dying provides a context for the darker elements and fears to emerge that relate to how we perceive we are connected to others. Thus death as portrayed in the movies reveals the death process as a raft of issues including morality, emotional states, and fulfillment within a familial, social, and cultural context.

Research reveals that the viewing of death in the movies and television represents an ongoing experience that has replaced the typical religious rituals of the past. But the death experience is rarely explained because the whole point of these portrayals is to reveal an example of personal and societal incongruity and inconsistency. This connection between lack of full explanation but explicit portrayal of death in action is typified in the Coen brothers' 2007 movie *No Country for Old Men* (2007). While the apparent unpredictability of life and its relationship to death are explored in a similar fashion to *The Departed,* this film also deals with the futility of finding meaning in life itself given that death comes to all. The film ends with the main character preferring to accept a quiet good death as opposed to the violent death that has occurred all around him as he sought to forge an ethical path in his world.

An interesting death perspective that these acclaimed films also bring to light is the relationship between death and screen violence. Current research had identified that despite current societal concerns, there is little supporting evidence that the viewing of death and violence actually produces ongoing aggression in individuals. It has been suggested that the viewing of death within scenes of hostility is a necessary part of human development and that if avoided, these aspects will constantly resurface in popular culture. This area represents a much needed focus for research.

Death as Final Abandonment

An integral part of the psychological response to death is based on the belief that the after-death experience represents the ultimate form of dissolution when the body is decomposing and social connectedness has also dissolved. However, death opens up the question of whether there is any form of transformation after life. Linked to concepts such as the soul, the supernatural, and the afterlife, fear of death has been explained in many ways across all visual genres. The possibility that this fear could be the ultimate form of freedom, albeit unknown and indescribable, has also been explored. Science fiction horror films, war documentaries, and movies linked to popular culture envision myriad postdeath realms, as well as the possibility that death is total oblivion.

The elements of death and dying represent a fear that death is the absolute end of physical and social existence, the fear that death is nothing but a void without end, representing the notion of total abjection and the absolute fear that the death process leads to total meaninglessness or absolute nothingness. Death of the individual is represented as a marginal phenomenon or a process of reaching toward and beyond the natural limits of the life cycle.

While in many recent movies death is linked to the notions of futility, ultimate finality, and cosmic abandonment, several recent television series portray death in a different perspective. *Crossing*

Over, Medium, and *John From Cincinnati* depict death as a point of transition and transcendence. Also, these screen depictions associate death with moral values, ethical considerations, and principled lives. This difference in focus is emblematic of the ongoing tension and ambivalence that death constantly brings to the human condition.

If death is the central tenet of narrative, then perhaps our infatuation with television and the movies is based on the notion that they provide a sanctuary of viewing an unfolding of what has been called the "little deaths" of others, so that when the larger imminent reality or certainty appears, we are more prepared and accepting of the inevitability.

Phil Fitzsimmons

See also Mummies of Ancient Egypt; Photography of the Dead; Popular Culture and Images of Death; Pornography, Portrayals of Death in; Zombies, Revenants, Vampires, and Reanimated Corpses

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Deviance, Dying as

The word *deviance* is derived from the Latin verb *deviare,* meaning "to deviate." To deviate is to extend outside the parameters of normative expectation. Dying as deviance, then, is a death that occurs in other than an expected condition, manner, or situation. This entry explores this unique concept within the context of death and the human experience. Thus an analysis of deviance addresses several issues relating to who deviates; from what these individuals deviate; what death-related actions constitute deviation; and how society reacts to death perceived as a deviant act.

Because deviance is understood to be outside the realm of the expected, the concept of deviance is a distinctly human affair. Predicated on the expectation that certain behaviors and attitudes are to be followed, behavior that is contrary to expectation elicits a negative response. It is important to note, however, that what constitutes deviant behavior for some is not necessarily deviance for all. As the postmodernist world becomes more tolerant of diverse perspectives, the interpretation of the seriousness and importance of deviance may become more difficult and differentiation between difference and deviance more problematic. On the other hand, the impact of national strategies to address perceived terrorist threats may influence behaviors and attitudes in a direction of national solidarity and, consequently, toward a more universally standardized expectation of behavior. Not all deviance is considered to be serious, though some deviant acts are viewed as both deviant and wrong because they violate social norms agreed upon and upheld by virtually all societal members. Other deviant acts may be interpreted as wrong by some and not by others.

Deviant death presupposes a culturally specific set of beliefs, values, and norms that are, in some way, violated through the experience of death. Such experience includes those who die as well as individuals who, while in close proximity, may be a participant in lifesaving or death-inducing acts or be among those who observe the death.

Explanations of Dying as Deviance

A variety of sociopsychological explanations are useful for understanding and interpreting dying as deviance. Statistical deviance means that the form of deviance occurs infrequently. This could include desirable spontaneous remission from a terminal or chronic disease or an undesirable diagnosis of a particularly rare disease. This framework is without a moral sense of deviance and simply serves as a measure of occurrence.

An absolutist concept of deviance presupposes that certain behaviors and/or attitudes are simply

inherently and intrinsically wrong. This perspective assumes full societal agreement on what is, and is not, deviant. Laws are viewed by some as a codified response to certain kinds of serious deviance. Others argue that such laws are developed to protect the interests of the privileged and powerful.

The symbolic interactionist perspective holds that deviance is so defined through interpretation; that is, the *act* is perceived by others to be deviant. When an act has *meaning*, that meaning is socially constructed through different or conflicting interpretations of the same behavior. For the symbolic interactionist, the social world is filled with symbols that are meaningful, but these symbols are, to an extent, fluid in their use/application. For example, death of enemy targets caused by military personnel during active warfare is defined and interpreted as desirable, whereas death caused by military personnel during a barroom brawl is defined in a significantly different way. Thus dying is likely to be interpreted differently depending on the context in which dying occurs.

Death as Unnatural

The notion of dying as deviance does not stem from the event of death itself, as all living creatures naturally die. Dying as deviance could result from the perception that the death occurs at an unusual or unexpected time during the life course, either too early or too late. A good death implies a death after a long and fruitful life, wherein the deceased had contributed to the community, as well as having experienced life course events that embellished his or her personal sense of individuation. Death that violates the usual ordering of death—for example, a child's death preceding the parent's death—also can be viewed as deviant. And death by homicide may be a way for humans to address the incomprehensibility of death and enact qualities of the divine since life and death are understood as originating from, and provided through, the divine deity.

Biological Death

Biological death, as the cessation of body organ function, may be framed as deviant if the person pronounced dead unexpectedly and inexplicably regains organ function. In rare cases individuals who have been pronounced biologically dead have spontaneously revived after periods exceeding 12 hours. Dying as deviance may be applied to those who are revived after clinical death has been pronounced. Many individuals who have regained biological functioning after having been pronounced clinically dead provide accounts with strikingly similar qualities. Some adherents of spiritualism and occultism present such accounts as supportive evidence of the certainty of an afterlife, whereas supporters of the scientific perspective dismiss such accounts through arguments that drugs, oxygen deprivation, limbic lobe syndrome, endorphins, and/or sensory deprivation may be physiological conditions influencing perception at death. The address of death in connection with the realm of the occult or supernatural may position the experience or idea of death as deviant, particularly in cultures operating under the paradigm of science.

As the living human being has a significant tendency to identify with the body, death as the demise of the corporal may be viewed as deviant, a departure from the normative realm of the living, physical body. This attitude is contrasted with the notion of the condition after death as the realm of the spiritual. So, too, death as a condition for entry into the "underworld" may be regarded as deviant, a rupture from the normative world of life.

Forms of Dying as Deviance

The form of death—for example, death through crime, death as sexually related, or death as self-deliverance or suicide—may be understood as deviant, as contrasted to natural death caused by old age. In fact, there exist a number of ways dying may be viewed as deviant.

Suicide

Émile Durkheim explained suicide through the analysis of social structure rather than as an exclusively personal act. He proposed four different types of suicide based on the degree of, and combination of, social regulation and social integration. Durkheim found that people who experienced extremely high or low levels of either social regulation or social integration, had a greater tendency to commit suicide. Altruistic suicide often involves

highly integrated individuals whose lifestyle includes rigid proscriptions and restrictions, such as those expected of military personnel, for example, Japanese kamikaze pilots during World War II.

Japanese culture has long recognized an act of completed suicide as vindication from shame, disgrace, and dishonor. However, many other cultures regard suicide as *anti*social. To complete suicide is to reject participation in the social world. Such a rejection is a movement away from the world of sociability and therefore is viewed as deviant. Thus, suicide comes under the scrutiny of the law.

Many organized religions address the issue of suicide. Suicide may be understood as violating expectations of religious mores. The act of suicide always violates the expectations of religious-minded people. To override the will of a god, through willful acts of inducing one's own death, is seen as an offense. Some contemporary religions have guided congregations to engage in ideologies resulting in death. Marshall Applewhite, leader of Heaven's Gate religious cult group, encouraged more than 30 group members to complete suicide within the context of the group's religious ideology. Virtually all religions are concerned with transitions from life to death. The usual pairing of death and religion is not generally perceived as deviant. The encouragement of Heaven's Gate to self-deliverance is unusual within the context of religious direction in the contemporary West.

Finally, clinical psychology views self-harm as a pathological behavior through the assumption that the mentally healthy person does not engage in self-harm. It is the mental illness of the suicidal person that influences their actions.

Autoerotic Fatalities

Autoerotic fatalities are not categorized as suicide because criteria for suicide include the intention of death. Because autoerotic fatalities are sexualized activities wherein a potentially dangerous agent is used for heightening sexual arousal, accidentally killing the victim, the intentionality of death, as in suicide, is absent. Autoerotic asphyxia is a typical cause of death in the majority of autoerotic fatalities. Accounts of autoerotic fatalities evidence ritualistic qualities that often mirror address of the taboo within organized ritual. Many preliterate collectives demonstrate attitudes and responses to taboos through formal rituals. Rituals in such cultures, and even in Western culture, tend to be enacted at life continuum points representing significant changes or transitions from one social status to another.

Atypical autoerotic fatalities include causal factors such as aspiration of vomitus, electrocution, exposure, and Freon or nitrate inhalation. Autoerotic fatalities may be viewed as one of a variety of risk-taking behaviors. Whether or not risk taking is interpreted as deviant has to do with cultural attitudes toward particular behaviors that may be categorized as risk-taking behaviors.

Andrew Sherwood

See also Altruistic Suicide; Autoerotic Asphyxia; Good Death; Sex and Death; Sexual Homicide

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Devil

The devil by definition is a powerful force of evil, either a real spiritual personality or a metaphor for human evil. As such, the concept of the devil exists only in monotheist religions including Judaism, Christianity, Zoroastrianism, and Islam. Other religions (including Greco-Roman, Egyptian, Mesopotamian, and Canaanite beliefs), traditional

Eastern religions such as Hinduism and Buddhism, and animist religions all have spirits who are malevolent or else combine malign with benign qualities, but all lack a single power of evil. In monotheist religions there are demons (minor evil spirits), but they are subservient (as are evil humans) to the great and single devil, who is known by many names, including Satan, Lucifer, Mephistopheles, Azazel, and the Prince of Darkness.

Religious Traditions

Israelite Religion

The figure of the devil is extremely vague in the Tanakh (the Hebrew Bible or Old Testament), where the word *satan* basically means a stumbling block or an opponent of any kind, though a personal Satan appears in a few passages such as in the book of Job. The devil first attained real prominence in the period from 200 B.C.E. to 100 C.E. in Hebrew and Jewish pseudepigrapha (anonymous writings ascribed to ancient figures such as Enoch and Baruch) and in 1st-century C.E. Christian writings, specifically the New Testament. From 100 C.E., rabbinic and Talmudic views prevailed in Judaism and have generally given the devil very little importance.

Early Christianity

In the New Testament gospels, Christ is tempted near the beginning of his ministry by the devil in the wilderness; there the devil claims the power to hand over all earthly riches and powers to Christ, a claim and an offer that Christ refuses. Christ frequently rebukes the devil and casts out (exorcizes) demons from the victims that they "possess." In the writings of Paul and John, diabology (theology about the devil) was developed: He was an angel created good by God, but through his own free will he chose to serve his own ego rather than to love God. As a result, he and the other angels who chose to follow him were cast out of heaven; these fallen angels are the demons who now act under Satan's leadership to block God's plan for the cosmos by corrupting God's creatures. It is the devil who tempts Adam and Eve (representing all humanity) to sin and continues to attack humans by possessing them (taking control of their bodies), obsessing them (launching physical and mental attacks on them), and tempting them. The devil has great power over humanity, though he can never compel anyone to sin, and the central purpose of Christ's mission is to free us from the dominance of sin. By dying for us on the cross Christ breaks Satan's power; still, we retain our free will to sin until the last day, the Last Judgment, at which point Christ returns to cast Satan and his demons into hell forever. Hell, a Christian development of the Jewish Gehenna, is a place of torment for sinners; it is usually located under the earth's surface or in some undefined outer darkness. Its chief characteristic is the absence of God, light, and love.

Christian Tradition

Throughout its history Christianity confirmed these views, developing further details. The early church established hell as the devil's dwelling place from the moment of his fall from heaven yet asserted that he can issue out and roam the world, seeking the ruin and destruction of humanity. The devil and the demons have a dual role in hell: On the one hand they are imprisoned there themselves, and on the other they are the jailers of sinful humans there. Most of the baptismal formulas of the early church included a formal renunciation of Satan, a ritual widely preserved to the present day. The church followed the example of Christ and his disciples by exorcizing demons from the possessed, a procedure still practiced in some denominations. The presence of demons was intensely and widely felt in the first few centuries of the church, particularly in monastic communities, who often felt that their prime purpose was to wage war against Satan. The devil is an angel, an asexual being, but he can assume the form of either sex for the purpose of temptation. In serious writing, the devil is seldom imagined to be female.

Sin, Death, and Hell

The devil was tied to death; it was because humanity (in Adam and Eve) yielded to Satan that humans lost their immortality. Since then, humans are mortal until Christ restores their immortality. The central purpose of Christ's Passion is to free humans from the tyranny of sin and death. By the 3rd century C.E. it was established theology that between his death and resurrection, Christ had

descended into hell to liberate the just who had been consigned to it before his incarnation. At the same time it was becoming common for Death to be personified along with the devil and hell as one of the three great enemies of humankind. From the 4th century a growing body of liturgy, literature, and legend portrayed the dramatic moment when Christ appears at the gates of hell and vanquishes Death, hell, Satan's demons, and Satan himself. Legend and art also established that at personal death, the devil or a demon appears at the judgment of the dying person. When a person dies, the devil accuses him or her and struggles (vainly) against a benign angel to tilt the scale of justice against the dead. Then, if the person is justly condemned, the demons bear off the person's spirit to hell. In no way, however, can the devil carry off anyone whose character is turned away from selfishness and toward love of God.

Opposites: Dualists and Muslims

Certain heretical groups, mainly gnostics, exaggerated the role of the devil to extremes, sometimes asserting that he and Christ were locked in almost an equal struggle to control human society and the whole cosmos. Such ideas were linked to the Zoroastrian idea of a nearly equally balanced cosmic war between the god of light and the god of darkness. By the 7th century C.E., when Muhammad received the Qur'an, the devil was much on the mind of both Christians and Zoroastrians, and in the Qur'an he appears with the name of Iblis or Shaytan. Muslims have always feared and despised him—pilgrims to Mecca continue to stone the pillar representing his power. Though strictly Allah is all-knowing and all-powerful and is threatened or limited by no opposing power whatsoever, it is his will to allow the devil to tempt and persecute humans, whose only hope is *islam* (submission) to Allah. In Islam the conviction that the Qur'an is the literal word of God continues to discourage any deconstruction of any of its passages, including those about Shaytan or Iblis.

Later European Developments

Both Christian (Orthodox, Catholic, and Protestant) and Muslim theologians continued to develop the idea of Satan right into the modern era without changing the basic concept. The Protestant Reformation in 16th-century Europe did virtually nothing to change the theology of the devil, although the struggles between varieties of Christianity in that and the following century caused an increased belief in the presence of Satan and in the reality of witchcraft. However, beginning in the 18th century, Christian Europe developed increasing skepticism about religious authority, tradition, and the Bible. That had two huge effects on the concept: the development of a "liberal Christianity" that had little room for the devil, and the development of agnosticism and atheism that rejected Christianity and religion as a whole.

Those two effects are felt mostly in Europe and, to some extent, in the United States, but in countries where Christianity is on the rise—Africa, Latin America, and China, for example—biblical and traditional views continue to prevail. In Western countries the decay of belief in the existence of Satan can be observed in four different attitudes. Among the dominant intellectual elite, the devil is a silly and superstitious idea that has been proven wrong both by philosophical materialism and by literary deconstruction. For this elite, belief in the devil is one of a number of preposterous ideas that make Christianity meaningless. Among the minority of the elite who are Christian, the assumption is that the devil may be said to exist, but only as a metaphor for human evil. Among the clergy, most Catholic and "mainline" Protestants strenuously try to avoid mentioning the devil or hell, partly because they feel that such beliefs make Christianity less plausible and partly because they fear losing their congregations by making them feel uncomfortable. Some clergy, however, especially Evangelicals, teach that the existence of Satan cannot be questioned in the light of clear biblical teaching. In popular culture, hedonistic materialism and feel-good self-esteem discourage thinking about the devil, sin, and death.

Contemporary Satanism

Since the 1960s there has been a strange set of countercurrents in the West, especially in the United States. Renewed belief in the powers of Satan led to an increase in exorcisms. Fear of Satanism became a mini-craze in the 1970s and 1980s, when a number of people lost their jobs

and even their liberty because of lurid, false accusations, and a few people declared themselves to actually be Satanists. Of these last, most are simply poseurs, but a few actually believe that Satan is the good spirit and God the evil one. Such a belief springs from the Romantic movement of the 19th century, when political and cultural revolutionaries glorified rebellion and regarded God (along with church and state) as a tyranny to be overthrown. Among most people today who believe in the existence of the devil, however, the emphasis is much less on the negativity he represents than on the positive hope for harmony with God. In all monotheist religions, the devil has power only to tempt and not to control; therefore a person who has led a life of love and obedience need have no fear of the devil at the moment of death or in an afterlife.

Jeffrey Burton Russell

See also Christian Beliefs and Traditions; Eschatology; Eschatology in Major Religious Traditions; Hell; Jewish Beliefs and Traditions

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Día de los Muertos

See Day of the Dead

Disasters, Man-Made

Disasters are significant disruptions of a social system that compromise that system's ability to respond to the disruption on its own. Disasters can vary widely in their geographic scope and impact. For example, a disaster might impact a small municipality of less than 1,000 people or impact hundreds of thousands of inhabitants of a major metropolitan area. Man-made disasters are those disruptions that originate from the intentional or accidental actions of humans. The sarin gas attack of March 20, 1995, in the Tokyo subway and the massive terrorist attack on September 11, 2001, are examples of the former, whereas the radioactive steam emission from the Three Mile Island Nuclear Generating Station on March 28, 1979, and the Exxon *Valdez* oil spill of March 24, 1989, exemplify the latter.

Disaster Types

There are many types of man-made disasters. They include the disruptions that result from breakdowns in the technology that humans have created. Examples could include dam failures, radiation breeches, chemical spills, and other far-reaching technological failures. Other man-made disasters include intentional acts, such as technological sabotage and bioterrorism, as well as other

terroristic acts that create a significant disruption in a social system.

A disaster is more than an emergency. It is an event of such magnitude that local first responders and emergency managers are overwhelmed and unable to cope, on their own, with the scope of the event. In addition, disaster events that are triggered by illegal actions create an additional overlay on the response to the event. Local, state, and federal law enforcement officers may have jurisdiction, which can complicate the initial and continuing response to the situation. The organized efforts to respond to, as well as prevent, mitigate, and recover from disasters that are precipitated by terrorist actions are termed *homeland security*.

The Sarin Attack

The sarin gas attack involved the release of packets of the chemical during morning rush hour on the Toyko commuter transport system. One drop of this chemical agent is sufficient to kill an adult. In total, there were five separate releases of the chemical on different trains by a team of attackers that resulted in 12 deaths and over 1,000 injuries. The event has been described as domestic terrorism, although some researchers are now viewing it from the perspective of a toxic disaster. A toxic disaster has some unique features, which include the "invisible" nature of the attack. Specifically, radiation, germs, and chemicals are invisible to the human eye and thus create special stresses. The stresses flow from the lack of awareness of how the toxin will impact victims over the long term. In particular, there may be no specific end point for the impact of the toxin as it may have increasing and unknown negative health impacts over time. As such, there can be a variety of mental health consequences concomitant to the exposure. These may include depression, anxiety, somatization, post-traumatic stress disorder, and other negative outcomes.

Three Mile Island

The Three Mile Island event involved the escape of radioactive steam due to equipment failures and human errors. The governor issued an announcement that those 3,500 individuals in the immediate area should evacuate. Surprisingly, reports indicate that a total of 150,000 to 200,000 people left the area, some for several weeks. The event caused no immediate deaths, and a variety of epidemiological studies have focused on the longer-term health consequences to residents. This type of "accident" has led commentators such as Kai Erikson to describe Three Mile Island as falling into a "new species of trouble" in the form of technological disasters. Included in this grouping are events such as Chernobyl, Bhopal, and the Buffalo Creek flood disaster. As is the case with the sarin gas example, these technological disasters involved toxins that elicit a special type of fear as well as a variety of psychological symptoms. This is because toxin-based disasters may leave a residue and create a contamination effect rather than a time-limited damage trajectory as in the case of such natural disasters as tornadoes. Some toxin-based technological disasters can invisibly wreak havoc on the human body, and so victims can carry the impact of the disaster with them continually for the remainder of their lives.

Man-made disasters have increased in frequency and their incidence has resulted in significant human mortality and associated experiences of grief, bereavement, and mourning among survivors. It is important to recognize that loss in disasters includes personal and public dwellings, environmental resources, memorabilia, and other possessions, as well as the loss of human life. This entry presents issues related to human mortality and loss from the perspective of the disaster phase model. The disaster phase model is a conceptual framework employed in the field of emergency/disaster management that provides a general orientation to the sequence of disaster events.

Disaster Phases

Disasters, both natural and man-made, are in the purview of the developing discipline variously called emergency management or disaster management. The term *emergency management* is used in this entry as it has become the traditional label for the network of managers, planners, and others who form the developing profession whose work involves the identification and management of risk.

A frequently used resource for examining activities related to disasters is the disaster phase model. This model conceptualizes disasters as a cycle

involving preparedness, response, recovery, and mitigation. Preparedness refers to those activities prior to a disaster that involve planning, training, or notification and warning systems. Response constitutes those activities during a disaster that are directed to immediate emergency assistance such as medical care, security, evacuation, search and rescue, and related activities. Recovery is a process that is thought of in short-term and long-term dimensions. Short-term recovery typically refers to weeks or months while long-term recovery spans years and, in some cases, decades. Mitigation activities focus on eliminating or reducing a risk. These activities can be structural, such as using of building codes or levees, or nonstructural, such as developing education or insurance programs. These phases can overlap as the activities of one phase can spill over or be embedded in the other.

This disaster phase model will be used to review death and dying issues as they relate to man-made disasters. Under each category of the disaster phases there is a detailing of what Robert Kastenbaum has described as the death system. The death system is the matrix of people, places, times, objects, and symbols that constitute the social response to death.

Preparedness Phase

From the death systems approach, preparedness would include those predisaster activities that have the objective of saving human life and reducing human suffering. This includes all first responder systems. Given the possibility of death in many man-made disasters, preparedness would also include the organization of specialized counselors with skills to work with survivors of the disaster as well as those who have lost family or friends in the disaster.

Preparedness activities also include the development of Disaster Mortuary Operational Response Teams (DMORTs). DMORTs began in the 1990s and now include over 1,200 volunteers who are grouped into 10 regional teams. These teams have the following responsibilities: temporary morgue facilities, victim identification, forensic dental pathology, forensic anthropology methods, and the processing, preparation, and disposition of remains. The DMORT program is supported by two disaster portable morgue units, one located in Rockville, Maryland, and the other in San Jose, California.

In a more general sense, the growth of death education at all levels is a form of preparedness, as knowledge of grief, bereavement, and mourning processes enhances the understanding of a wide range of individuals, and this can provide an additional preparedness resource. In particular, the growth of death and dying courses on higher education campuses is particularly beneficial. Many universities with emergency management programs may have courses in death and dying that can provide critical background knowledge for those who deal with mass fatalities and the needs of those who have lost significant others in a man-made disaster.

Response Phase

The activities of preparedness merge into the response phase. DMORT is a response-oriented program and is requested only when more deaths occur than the local responders can manage. The response phase in disasters is dominated by first responders, such as firefighters, HAZMAT teams, law enforcement, and related professionals. Specially trained counselors are also an important part of the response phase when deaths or other traumatic events have occurred.

The increase in mass casuality events has led to a proliferation of books and operational texts that provide guidance for managing these types of situations. Memorialization can also become a focal process in the response phase of a disaster. Sylvia Grider refers to these informal cultural responses as "spontaneous shrines." This form of informal memorialization response was evident after the Oklahoma City Murrah Building bombing in 1995 as well as at the sites of the 2001 terrorist attacks.

Recovery Phase

Recovery work in the area of death and dying focuses primarily on the counseling dimensions and less on structural activities. Counseling activities can be directed to a wide range of individuals who may need special support. These include families, friends, and coworkers of the deceased, as well as those who assist in fatality management, body recovery, and body identification.

Recently, special attention has been directed to the needs of children bereaved after the September 11, 2001, terrorist attacks.

Memorialization activities are also an important part of the social psychological process of recovery. Terrorist-triggered disaster events that result not only in multiple deaths but also in extensive infrastructure damage are often followed by the construction of memorials to commemorate the lives that have been lost. Commemorative efforts after the destruction of the World Trade Center towers are perhaps the most visible example of efforts to symbolize the loss of life, as well as other losses, experienced from the attack. The Pentagon Memorial is another example of these efforts. A variety of other vehicles such as websites, t-shirts, posters, and other creations have become tangible expressions of loss as well.

Another important recovery activity that relates to the death system includes economic recovery. One traditional element in economic recovery from the loss of an individual life includes resources such as life insurance. This is also a part of individual preparedness as families and households need to determine their level of financial risk if an income-earning member of the group dies and is no longer able to provide for the financial needs of dependents.

After some man-made disaster events, an attempt will be made to determine liability for the event. If negligence is determined, then survivors may be entitled to a significant financial settlement.

Mitigation Phase

The fourth phase of the disaster cycle is mitigation. Mitigation and preparedness are interlinked phases. Structural activities, such as levee construction or building codes, frequently come to mind when discussing mitigation. In the realm of death and dying, nonstructural mitigation such as education would be particularly relevant. Educational activities, for example, can be helpful in mitigating the impact of death by sensitizing individuals to the variability of grief and the typical range of responses to loss. An understanding of the range of responses can help individuals to normalize their experience or to seek assistance if the mourning process does not lead to resolution.

Memorialization relates to mitigation in that formal memoralization helps socially define and institutionalize the event. Formal memorial sites serve an educational function with the educational goal of maintaining the history of the event and its impact, thus establishing a tangible symbol of what should be avoided in the future.

Daniel J. Klenow

See also Accidental Death; Bereavement, Grief, and Mourning; Disasters, Natural; Memorials

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Disasters, Natural

Throughout history human beings have been confronted by the forces of nature. Natural disasters serve as vivid reminders of just how powerful those forces can be and how vulnerable societies are to them. Volcanic eruptions have buried ancient cities, droughts have devastated entire regions, and tidal waves have inundated small fishing villages and major tourist destinations alike. The tragic and lasting effects of these kinds of events are reflected in folklore, literature, and film and passed on from one generation to the next. In addition to their potential for widespread physical destruction, natural disasters disrupt

society's normal functioning, stretch community resources beyond their limits, and often leave sizable death tolls in their wake. Yet, human societies are surprisingly resilient in the face of catastrophe. Survivors find ways to effectively cope with their losses, most communities manage to rebound, and social life continues. Large-scale disasters do, however, pose some major challenges. Social inequality, for example, plays a vital role in shaping people's vulnerability to disasters—that is, some social groups are more likely than others to be negatively impacted by them. Additionally, because they result in mass fatalities, natural disasters have important implications for the systems that exist in every society to handle and process the dead, sometimes leading to temporary changes that violate established cultural practices and exacerbate the suffering of survivors.

Types of Natural Disasters and the Deaths They Cause

The UN International Strategy for Disaster Reduction estimates that from 1991 to 2005, nearly 1 million people worldwide died as a result of natural disasters. Based on that estimate, approximately 65,000 lives are lost each year, a number that is certainly not trivial but much lower than other risks present in modern society. In the United States alone, for example, the National Highway Traffic Safety Administration reports that approximately 45,000 motorists die each year in automobile crashes, and according to the American Cancer Society, more than 500,000 people die each year from cancer. It can be concluded, therefore, that a person's risk of dying in a natural disaster is relatively low compared to other, more common causes of death. However, it should be noted that this risk goes up or down depending on where a person lives in the world and his or her demographic characteristics, including race, social class, gender, and age.

In estimating the fatal impacts of natural disasters, it is common to distinguish between three major categories of events: weather-related phenomena, geological processes, and biological episodes. Weather-related disasters include hurricanes, tornadoes, droughts, heat waves, wildfires, and floods. Geological events include volcanic eruptions, earthquakes, and tsunamis, which are massive waves triggered by seismic activity. Biological disasters include epidemics of rapidly spreading contagious diseases and serious cases of insect infestation. Over the past decade and a half the most commonly occurring disasters have been floods, hurricanes, tornadoes, epidemics, and earthquakes. The most deadly events have been earthquakes and tsunamis, causing almost half of all disaster-related deaths during that time period. This fact is not surprising given that the 2004 Indian Ocean tsunami, which caused approximately 250,000 deaths, occurred during this time frame, as did major devastating earthquakes in Japan, Turkey, Iran, and Pakistan. Hurricanes, tornadoes, and other windstorms have caused approximately 25% of disaster-related deaths in the past 15 years, and the remaining deaths are distributed across the other disaster types.

Beyond the obvious differences in their physical properties, disasters also vary along other important dimensions, all of which have consequences for the ways in which people experience them. For example, some disasters, such as earthquakes and tornadoes, strike very quickly, whereas others, such as droughts and hurricanes, have a much slower speed of onset. As a result, the latter events allow for a considerable period of forewarning, during which time people can take protective measures and get themselves out of harm's way. Conversely, rapid-onset events offer little or no advanced warning, thereby increasing people's risk of injury or death. Disasters also vary in terms of the magnitude, scope, and duration of their impacts. At one extreme, tornadoes tend to last only for a short period of time and produce damage that, while substantial, is limited to a relatively small geographical area. Droughts and epidemics, on the other hand, can last for days, weeks, or even months and cause widespread damage across an entire region.

While there are basic differences between various types of natural disasters, it is important to note that there are also significant and meaningful similarities between them. For example, all disasters share in common the fact that their effects are felt by groups, not just individuals. Certainly, experiencing a traumatic event can have profound consequences for an individual, but that event is only considered a disaster if it affects multiple individuals at once. In other words, disasters, regardless

of their physical properties, are collective events, not personal traumas; this is an important distinction that has consequences for how people experience and cope with them. Another common feature shared by all disasters is that they place extraordinary demands on local communities, requiring them to rely on the assistance of outside agencies and volunteers in order to effectively respond. Despite the traumatic and extraordinary nature of disasters, communities confronted by them tend to respond in a predictable and surprisingly prosocial, resilient manner.

Community Impacts of Natural Disasters

A common misconception about natural disasters is that they produce overwhelmingly negative effects. It is commonly believed, for example, that in the wake of a major disaster there will be widespread panic, looting, and other antisocial behavior. It is also often assumed that individual victims will experience acute post-traumatic stress disorder and other psychological problems, immobilizing them in a state of severe shock and preventing them from being able to take care of themselves and their families. Professional emergency responders, it is feared, will abandon their jobs in order to tend to personal matters, leaving the community in a state of chaos and anarchy. The mass media, of course, plays a crucial role in the perpetuation of these and other disaster myths, using distorted images and sensationalized accounts of human suffering to appeal to viewers, readers, and listeners. In the aftermath of Hurricane Katrina in 2005, for example, the media portrayed New Orleans as a city in shambles in which civil society and the rule of law had collapsed.

The reality of community response to disaster is quite different from the negative view purported by the media. Even in the midst of extreme physical damage and widespread death and injury, people exhibit remarkable strength, resilience, and altruism in response to major natural disasters. During the emergency response period, crime rates typically go down and helping behavior increases dramatically, as individuals and organizations work together in novel and innovative ways to meet heightened demands brought on by disasters. Informal volunteer groups form to carry out search and rescue activities, and donations begin to pour in from neighboring communities, as people immediately begin putting their lives back together. In stark contrast to the negative view portrayed by some media, most responses to natural disasters exhibit high degrees of social order, organization, and creativity.

Social scientists have found this pattern of prosocial behavior to be consistently present over the past several decades, leading them to conclude that natural disasters are capable of producing a therapeutic effect on the communities that experience them. Having gone through such a stressful experience together, community members develop a stronger sense of collective identity, efficacy, responsibility for each other, and shared purpose. It is important to note, however, that these positive outcomes can be short-lived, quickly giving way to feelings of unfairness and exclusion as decisions about relief and recovery expenditures are made. Furthermore, there is a significant amount of research suggesting that this argument does not apply to technological disasters, including nuclear power plant incidents, toxic chemical releases, explosions, and other human-induced crises.

While natural disasters are capable of producing some positive effects, they also pose significant challenges for human societies. For example, although they are widely perceived to be random and unexpected, natural disasters actually discriminate, subjecting some groups to their harmful effects more than others. Additionally, when they result in a large number of deaths, natural disasters sometimes force communities to alter the ways in which dead bodies are handled, causing added stress for survivors and complicating the recovery process.

Social Inequality and Natural Disasters

Social inequality is present in all societies—that is, things that are socially desirable and undesirable are distributed in an unequal fashion. Social desirables include such things as money, power, and education, whereas undesirables include poverty, environmental pollution, criminal victimization, and other social problems. The bases of social inequality vary from one society to the next, but the most common determining factors include race, social class, gender, age, and region. In many countries social movements have formed to actively promote

and protect the rights of women, minorities, and the poor, but problems of inequality persist.

The consequences of social inequality are plainly revealed in the context of natural disasters. In the past 15 years, approximately 90% of the deaths caused by natural disasters worldwide have occurred in developing countries, such as India, Pakistan, Bangladesh, Indonesia, Turkey, Iran, El Salvador, Mexico, and Guatemala. Conversely, the developed countries of western Europe, the United States, and Canada have experienced far fewer disaster-induced deaths. Thus, for the developing world, disasters exact staggering financial and human costs, while in the developed world their impacts tend to be primarily, though not exclusively, financial.

These numbers clearly demonstrate that social inequality operates on a global scale between societies, but it is also important to recognize that similar effects can be observed within a single society. Research in the United States, for example, suggests that racial minorities, the poor, and the elderly are more susceptible to injury and death in natural disasters than are others. Among survivors, these same groups have a more difficult time recovering from disasters.

The heightened vulnerability to natural disasters of some countries and groups relative to others is the result of many factors. At the country level, for example, the higher death tolls in some disasters can be attributed to a combination of population density, dangerous construction practices, and lax enforcement of building standards. In other cases, mass fatalities result in large part because of the lack of adequate early warning systems that would allow people to take necessary protective actions. Fatalistic attitudes that exist among some cultures can create a climate of apathy in which people accept high death tolls because they perceive disasters as acts of divine intervention.

At the local level, developers sometimes pressure planning commissions and city councils to allow them to build in high-risk areas such as floodplains in order to provide affordable housing to low-income, minority, or elderly residents. In other cases, affordable housing comes in the form of mobile homes, which lack the structural integrity to withstand a tornado or hurricane. For the elderly, social isolation can be a major factor that contributes to their increased risk of being injured or killed in a natural disaster, and for the poor it can be as simple as not having a car or enough money to leave when an evacuation order is issued.

Handling the Dead in Natural Disasters

In addition to the problem of social inequality, natural disasters also create logistical problems in terms of handling the large number of dead bodies. Every society has established procedures, structures, and cultural practices in place for dealing with the deceased. Of course, there is tremendous cultural variation in terms of how death is processed, but there are several core concerns that cut across cultural lines. Social norms, and in some cases written laws, spell out the proper way in which a body should be handled, prepared, and presented; imbue certain actors with the authority and legitimacy to handle dead bodies and certify death; and prescribe culturally acceptable methods for grieving and coping with the loss of human life. These practices, which have been passed down from one generation to the next, work well under normal conditions, but natural disasters are extraordinary events in which death occurs on a massive scale. As a result, these practices are sometimes modified in the aftermath of major disasters, which can have both functional and dysfunctional results.

There are times when death practices have to be modified simply because of the sheer number of fatalities involved. For example, under normal conditions it is possible for a few trained death professionals to recover bodies as they surface one at a time, but during a disaster it is sometimes necessary to recover tens, hundreds, or even thousands of dead bodies. Out of necessity, then, death specialists have to rely on the assistance of volunteers, many of whom have no professional training in dealing with emergencies. The involvement of these volunteers poses a significant dilemma: On the one hand, they are exposed to potential psychological trauma resulting from their encounters with death; on the other hand, the death establishment is not equipped to handle the situation on its own. Another alteration to death practices that is sometimes necessitated by natural disasters is the creation of temporary morgues, which can include gymnasiums, parking structures, and ice rinks.

Under normal conditions a fairly small morgue is adequate for storing bodies until they can be identified by family members, but in a major disaster a larger space is required for the identification process. Once it has been identified, the body can then be transported to a mortician for preparation and included in traditional funeral rites.

Whereas some modifications to death practices are necessary and functional in light of the circumstances brought on by natural disasters, some changes can have dysfunctional results for survivors. In particular, mass burials or cremations can cause extreme anxiety for survivors, undermine the grieving process, and impede their ability to effectively cope with, and recover from, the tragedy. When bodies are disposed of in this fashion, it is often because community leaders fear that the presence of decomposing corpses will expose survivors to adverse health consequences and potentially cause an epidemic. Epidemiologists and public health researchers, however, have found that such concerns are unfounded and have actively discouraged the practice of mass burials. Sociologist Émile Durkheim offered insights that also suggest that mass burials can have dysfunctional effects for survivors. In his classic study of religious rituals, Durkheim argued that funeral rites in particular serve important functions in society. Most notably, for survivors they provide an outlet for the expression of grief, reaffirm the strength of the community, and remind individuals that despite their losses social life continues. When people are deprived of these socially meaningful rituals, it is more difficult for them to achieve emotional closure and lead a healthy life after a tragedy. Indeed, the social value of these rituals is vividly revealed by the tendency of survivors to commemorate disasters through the creation of informal and formal memorials and recognize anniversaries as time passes.

Coping With Natural Disasters in the Future

As people throughout the world continue to settle in hazard-prone areas, natural disasters will continue to occur. The financial costs of physical damage caused by these events will likely increase, and more lives will be lost. Although it may not be possible to prevent all disaster-related deaths, there are measures that can be taken to dramatically reduce the death tolls of disasters. For example, early warning systems that alert people of impending hurricanes, tsunamis, and other threats can be improved through additional research and made more widely available, including in the poorest countries of the world. Public officials responsible for communicating risk information and charged with emergency management responsibilities can make special efforts to reach out to the most vulnerable segments of the population, including the poor, the elderly, and minorities. Finally, national and local governments can do more to educate themselves about natural hazards and make better policy and land-use decisions that balance the need for short-term economic development and the longer-term safety and sustainability of their communities.

Gary R. Webb

See also Atrocities; Disasters, Man-Made; Terrorism, Domestic; Terrorism, International; War Deaths

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Discretionary Death

As a result of advances in medical technology and antibiotic therapy, the average life span in Western societies has increased significantly. Most people no longer die from infections or parasitic diseases but from protracted degenerative diseases; for this reason, dying may be a prolonged and painful process. This situation has paved the way for changes in hospital practices concerning death, where limitation of life support and even hastening of death are becoming increasingly commonplace. Consequently, a subtle but major conceptual shift has taken place regarding established notions of natural and unnatural death. Discretionary death thus defines and identifies a class of death situations that has become increasingly common and which entails neither natural death (defined as death without human intervention) nor unnatural death (defined as accident, negligence, or killing).

A New Technical–Medical Context

Modern life support technology in health care is able to uphold life functions in critically ill patients to a considerable extent and for a significant period of time. These forms of technology have been enormously successful in rescuing patients from medical crises, such as heart failure, stroke, hypothermia, traumas, and other acute life-threatening episodes and have made it possible to perform major surgical procedures.

Alongside the major benefits these technologies provide, they also lead to unintended consequences in the form of growing human and financial costs, for instance, the futile prolongation of dying processes in incurable patients. Furthermore, some of the rescued patients suffer from serious neurological deficits and/or poor quality of life. In response to these unintended consequences, the first standard guidelines for limiting life support in cardiopulmonary resuscitation and ventilation were issued in the 1970s in the United States. Later these guidelines were developed into institutionalized practice based on the principles of patient autonomy and informed consent.

Death and End-of-Life Decisions

Death preceded by decisions of limiting life support or forgoing of life-prolonging treatment are increasingly common today. (The limitation of life support is indicated by different designations such as do not resuscitate orders, allow natural death, forgo life-sustaining treatments, advanced directives, or withholding and/or withdrawing life support.) Comparative studies of end-of-life decision making in Europe and the United States indicate that the administration of drugs with the explicit intention of hastening death and decisions to limit life support without the patient's request are commonly practiced. Approximately 70% of all deaths in European intensive care units are preceded by a decision to withhold or withdraw support. Even larger figures are reported for neonates and infants in intensive care units in Europe and the United States. In several European countries one fourth of all hospital deaths are preceded by decisions to limit treatment or hasten it through palliative efforts.

Futility, Quality of Life, and Patient Autonomy

End-of-life decisions are related to several factors, including medical and social factors. The principal medical factors influencing the decision to limit or forgo life support are prognosis, condition of the patient, and assessments of the utility of treatment, that is, determinations of futility. However, considerations of whether the patient might benefit from further life support are not entirely medical as they entail judgments about the expected benefits for the patient as well as the avoidance of inflicting harm. Futility sets an upper limit for intervention, justifying turning over the process to nature, for which human agents are not responsible. In a sense, futility has developed into a pivotal normative concept that guides and supports judgment in the area of discretionary death

A second factor considered in decision making is the quality of life to be saved or prolonged. Linked to characteristics such as the patient's age and the perceived seriousness of the illness, these quality-of-life variables also have medical meaning. But the value judgments about the patient's quality of life (present and future), which are attached to age and the perceived seriousness of the illness, influence quick decisions such as those relating to the intensity and extent of resuscitative efforts in emergency situations.

A third factor is the wishes of the patient and/or the family regarding prolongation of life and under what conditions. This is based on notions of autonomy and the right of the patient to make decisions about his or her own situation. This type of determination can be extended to the next of kin as representatives and witnesses of the wishes of the patient.

Thus, three factors—futility, quality of life, and the autonomy rights of the patient—are key influences in discretionary judgment. These are not simply medical but also relate to social and normative dimensions. The distinction between natural and unnatural death, increasingly ambiguous, relates to a fundamental distinction in social life, namely, the difference between what we define as "natural" and what we define as "social."

Natural and Social Conceptualizations of Death

This distinction is particularly important because it attributes moral responsibility and legitimacy to particular events, resulting in responsibility being assigned to human agents for certain occurrences or freeing them from such responsibility.

The social and the natural are two distinct frameworks or sense-making categories associated with particular and distinctive discourses. The natural framework encompasses natural events or unguided, unintended phenomena that, from beginning to end, are due to natural determinants. The frame excludes human agency and intentionality. Causality is understood as chain of cause and effect without human intervention. Within this framework, standard medical terminology still refers to *natural death*, for example, when referring to unintended death or letting nature take its course, in contrast to intended death such as euthanasia.

The counterpart to the natural is the social framework. This is the conceptual domain of the act and action, which is expected to be normatively regulated. It implies motivation and intentionality of human agents. Occurrences embedded in this framework are interpreted as "guided doings"; that is, they are the result of human agency. Causality refers to purposeful actions of human agents and to intended or unintended effects of human judgment and action. Thus, in the social realm it is more appropriate to talk about deed and intentionality rather than of occurrences or events and their natural causes.

The introduction of notions of human agency in relation to such phenomena opens the way for normative concepts and moral judgments about human discretion and intention. Thus, nonnatural death is placed within a social frame, and social agents are held responsible in that criminal liability is attached to human acts that cause death. Omissions would not necessarily be considered criminal; however, they might be viewed as neglect of professional responsibility.

Understanding Discretionary Death

Discretionary death entails a classification of situations in which human intention and intervention are decisive. Although some uncertainty, confusion, and contentiousness are evident, such death as deed is not arbitrary. The moment of death and the means of death may be negotiated, especially with respect to when and how life support and levels of palliation are determined. Much end-of-life palliation is carried out under the doctrine of the "double effect," in that the immediate cause of death of a patient is not intended even if foreseen. Because this concerns dying patients, the term used is to *hasten* death and not *cause* death.

The increasing recognition of the rights of patients to choose not to be supported by all available technologically means sanctions the transformation of the moment and process of death into a deed, a matter of judgment and technological intervention. Typically, discretionary death situations entail discussions and negotiations involving not only responsible medical personnel but also the patient and/or relatives and friends of the patient.

Death as Negotiable

The emergence of a negotiated death is part and parcel of the discretionary death concept. Many patients and families negotiate, directly with physicians and other involved professionals, the patterns and course of treatment. These negotiations may also involve lawyers and hospital administrations and concern the possible liabilities from halting therapies, alternative and competing options, and issues of how aggressive or passive to be in terms of levels of intervention. As a result, decisions about withdrawing life support for comatose patients are rendered whether or not directives or testaments for their own care and final treatment are already in place. These negotiations may be informal and ad hoc or formal, depending on existing legal and administrative regulations.

Staging Death as Natural

Within the framework of discretionary death, life support technology may be used for staging a natural good death in the hospital in order to realize a special or unique representation of death. The patient's next of kin, for example, may be led to believe that a peaceful natural process is taking place. In this case, technology and intervention become constitutive of, rather than separate from, the natural. The situation is thus staged and negotiated in such a way that human intervention is defined and perceived as minimal, thus satisfying conditions for the natural frame. Another aspect of staging death in the form of a fictionalized natural process of death is the suggestion of replacing the term *DNR* (do not resuscitate) with AND (allow natural death); the euphemism AND is a softer expression concealing in part the discretionary judgments involved.

Once again, situations of discretionary death—because of the deliberations and negotiations as well as conditions of ethical and legal accountability—point out the prominent role of human agency.

Beyond Natural Death and Intended Death

The new technological developments outlined here and within a zone of discretionary death have unsettled the established model of death based on a dichotomy of death with two modes: natural or unnatural, along with the norms and social relationships based on each of these. Thus, given the new technological possibilities, deaths that do not fit this dichotomy and abnormalities, misunderstandings, and controversies are frequently reported in the medical literature as well as in the media.

Norms, laws, and shared understanding, which represented a basis of defining, interpreting, and regulating earlier judgments and action, often fail in the face of the new situations. These situations are noteworthy under the terms of limiting and forgoing life support, terminal sedation, passive or active euthanasia, physician-assisted suicide, and palliative care.

New Notions of Intentionality and Death

Another development is that physicians no longer represent agents engaged in death decision making. The physician-autonomy model is under challenge by the patient-autonomy model. In a world of negotiated pluralistic death, patients have an increasingly important role, as noted in social movements relating to the right to die and to physician-assisted suicide.

In response to the indignities of high-tech death, more flexibility and greater options in forms of dying, supported by themes in the broader culture of self-determination, personal empowerment, and secularized systems of meaning, are sought. In this milieu arguments are directed at reform in the law and in the practice of medicine.

Simultaneously, new norms develop not only within the medical profession but also among physicians and other agents representing the law, the courts, politics, the mass media, and the general public.

Whatever norms are eventually established must transcend particular interests and be shared across social sectors. The challenge is to develop norms and normative principles that are generally understandable and acceptable to a wide spectrum of social agents at the same time they serve to guide and legitimize physicians and other health care personnel who orchestrate the functional aspects of intensive care units and hospices with respect to discretionary death. Thus, the new morality of intervention has to define acceptable and unacceptable applications of these new technologies as well as to establish limits. At this time the application

of new technology results in the prolongation of bodily function that may no longer be considered worthwhile, or at least is questionable.

Nora Machado

See also Assisted Suicide; End-of-Life Decision Making; Euthanasia; Life Support Systems and Life-Extending Technologies

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Diseases

See Acute and Chronic Diseases

Disenfranchised Grief

Disenfranchised grief is defined as that emotion which people experience when they incur a personal loss that is not openly acknowledged, socially sanctioned, or publicly mourned. The term has been thoroughly explored in two books by that same title and is a generally accepted concept within the literature on grief.

The concept of disenfranchised grief integrated a sociological perspective into the study of grief and loss. Previous theory emphasized grief as an intrapsychic process. Kenneth Doka's work emphasized that this process is heavily influenced by the degree to which the other individuals and society at large acknowledge and validate that loss. Grief is complicated when others do not acknowledge that the individual has a right to grieve. In such situations, persons are not offered the rights or the grieving role (such as a claim to social sympathy and support) or such compensations as time off from work or diminishment of social responsibilities.

To understand the social aspect of grief, it is important to remember that every society has norms that not only govern behavior but also affect cognition as well. Every society has norms that frame grieving. Thus, when a loss occurs, these grieving rules include not only how one is to behave but also how one is to feel and think. They govern what losses one grieves, how one grieves them, who legitimately can grieve the loss, and how and to whom others respond with sympathy and support. These norms exist not only as folkways, or informally expected behaviors, but also in formal statements such as company policies that extend bereavement leave to certain individuals or regulations and laws that define who has control of the deceased's body or funeral rituals.

In the United States and many other societies, these grieving rules limit grief to the deaths of family members. When a family member dies, one is allowed and expected to grieve, often in a specified way.

Yet human beings exist in intimate networks that include both kin and nonkin. They harbor attachment to fellow humans, animals, and even places and things. Persons experience a wide range of losses—deaths, separations, divorces, and other

changes or transitions. When these attachments are severed, be it by death or any other separation, the individual grieves such loss in characteristic ways. Individuals may experience, express, and adapt to loss in many ways, some outside of the grieving rules. In such situations, the personal experience of grief is discordant with the society's grieving rules. The person experiences a loss, but others do not recognize that grief. That person has no socially accorded right to grieve that loss or to mourn it in that particular way. Some analysts suggest that individuals internalize these grieving rules. Thus, there can be an intrapsychic or self-disenfranchisement of grief where individuals believe that the grief they are experience is inappropriate, repressing the grief or converting it to feelings of guilt or shame.

The Disenfranchisement of Grief

There are a number of reasons that grief can be disenfranchised. First and foremost, in most Western societies, the family is the primary unit of social organization. Hence kin ties have clear acknowledgment in norms and laws. Although most individuals live their lives in "intimate networks," or associations that include both kin and nonkin, only kin have legal standing.

Another principle of Western societies has been rationality—meaning that beyond the family, policies should apply equitably to all. The grieving roles reflect that. Extending grieving roles to nondeath situations or to nonkin would create organizational burdens. Organizations would be forced to define levels of friendship or types of loss. They might be required to broaden the concept of bereavement leave, at considerable cost. Acknowledging the death of kin alone makes organizational sense. It recognizes the grief of kin when a family member dies, at least symbolically. By limiting the acknowledgment of loss to family members, organizations avoid confusion and potential abuse, affirming a single standard. This keeps organizations from having to assess on an individual standpoint, whether this loss or relationship is entitled to recognition. These policies then serve to reflect and project societal recognition and support, again reaffirming and sanctioning familial relationship.

They also point to another significant factor—the relationship of grieving rules to ritual. The funeral becomes the vehicle by which grief is acknowledged and sanctioned, and where support is extended. The primacy of a family at the funeral reaffirms that these survivors have experienced a loss and that their subsequent grief needs sanction, acknowledgment, and support. The rite of the funeral publicly testifies to the right to grieve.

Naturally, in a diverse society, even the losses disenfranchised by society as a whole may be acknowledged within a smaller subculture. For example, the death of a gay lover may not be fully recognized by family or coworkers, but the grieving partner may be recognized and supported within the gay community. According to Frank Eyetsemitan, these grieving rules may change over time. Younger cohorts, for example, may be more supportive of the loss of an unmarried cohabiting couple. Thus subcultures may mitigate the sense of disenfranchisement. Naturally this implies that grieving rules differ among cultures. What is disenfranchised in one culture may be supported in another.

Typologies of Disenfranchised Grief

Losses attributed to disenfranchised grief can be distributed into five broad categories:

The Relationship Is Not Recognized

Grief may be disenfranchised in those situations in which the relationship between the bereaved and deceased is not based on recognizable kin ties. Here the closeness of other nonkin relationships simply may not be understood or appreciated. The roles of lovers, friends, neighbors, foster parents, colleagues, in-laws, stepparents and stepchildren, caregivers, counselors, coworkers, and roommates (e.g., in nursing homes) may be long-lasting and intensely interactive; even though these relationships are recognized, mourners may not have full opportunity to publicly grieve a loss. At most, they might be expected to support and assist family members.

Then there are relationships that may not be publicly recognized or socially sanctioned. For example, nontraditional relationships, such as extramarital affairs, cohabitation, and homosexual relationships, have tenuous public acceptance and limited legal standing, and they face negative sanction within the larger community.

The Loss Is Not Acknowledged

In other cases, the loss is not socially defined as significant. Individuals experience many losses—some death related, such as perinatal loss, others nondeath related, such as divorce, incarceration, the loss of a job or material possessions, or a significant change in behavior that may be unacknowledged by others. There are many other types of loss, all of which may be profound but nonetheless may not be recognized or validated. Some may be intangible. For example, a teenager aspiring to a sports career and cut from a team or the parents of a child born with a developmental disability may experience a loss of dreams. Similarly, the loss of reputation, due to scandal, gossip, or an arrest, can be devastating. Even transitions in life can have undercurrents of loss. Aging, for example, leads to constant developmental losses such as the loss of childhood or other losses associated with different points of life.

The Griever Is Excluded

There are situations in which the characteristics of the bereaved, in effect, disenfranchise their grief. Here the person is not socially defined as capable of grief; therefore, there is little or no social recognition of his or her sense of loss or need to mourn. Despite evidence to the contrary, others typically perceive both the old and the very young as having little comprehension of, or reaction to, the death of a significant other. Similarly, mentally disabled persons may also be disenfranchised in grief.

Circumstances of the Death

The nature of the death may constrain the solicitation of the bereaved for support as well as limit the support extended by others. For example, many survivors of a suicide loss often feel a sense of stigma, believing that others may negatively judge the family because of the suicide. Similarly, the stigma of AIDS may lead survivors of an AIDS-related loss to be circumspect in sharing the loss with other.

The Ways an Individual Grieves

The way an individual grieves also can contribute to disenfranchisement. Certain cultural modes of expressing grief, such as stoicism or wailing, may fall beyond the grieving rules of a given society and thus be disenfranchising.

These examples and categories are meant to be illustrative of the many ways grief may be disenfranchised. They are neither exhaustive nor exclusive. An individual's grief may be disenfranchised for a number of these reasons. And, of course, this particular taxonomy draws examples attuned to contemporary Western culture.

Approaching the issue deductively, yet another taxonomy of disenfranchised grief addresses the question "What is disenfranchised in grief?" The answer to this question is that the state of bereavement, the experience of grief, and the process of mourning can all be disenfranchised.

Special Problems of Disenfranchised Grief

Though each of the types of grief mentioned in this entry might create particular difficulties and different reactions, one can legitimately speak of the special problems shared in disenfranchised grief. The problem of disenfranchised grief can be expressed in a paradox. The very nature of disenfranchised grief creates additional problems for grief, while removing or minimizing sources of support.

Disenfranchising grief may exacerbate the problem of bereavement in a number of ways. First, the situations mentioned tend to intensify grief reactions. Higher levels of guilt, anger, and confusion, for example, are often present in disenfranchised grief. Second, both ambivalent relationships and concurrent crises have been identified in the literature as conditions that complicate grief. These conditions can often exist in many types of disenfranchised grief.

Although grief is complicated, many of the factors that facilitate mourning are not present. In death-related losses, the bereaved may be excluded from an active role in caring for the dying. Funeral rituals, normally helpful in resolving grief, may not help here. In some cases the bereaved may be excluded from attendance. In other cases they may have no role in planning those rituals or in deciding whether to have them. In cases of divorce, separation, or psychosocial death, rituals may be lacking altogether. In addition, the very nature of the disenfranchised grief precludes

social support. Often there is no recognized role in which mourners can assert the right to mourn and thus receive such support. Grief may have to remain private.

Treatment of Disenfranchised Grief

In treating disenfranchised grief, it is critical to remember that it is treated as any form of grief, complicated by the fact that social support is limited. It is also suggested that the key to treating disenfranchised grief lies in analyzing what is known as empathic failure. Empathic failure refers to the factors that limit support, generating disenfranchisement. Once the cause of empathic failure is analyzed, therapists can devise interventions that develop or compensate for the lack of support. These interventions can include many modalities, including individual or group counseling, support groups, expressive therapies, or the therapeutic use of ritual.

Kenneth J. Doka

See also Chronic Sorrow; Communal Bereavement; Grief, Bereavement, and Mourning in Cross-Cultural Perspective; Grief and Bereavement Counseling; Prolonged Grief Disorder

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Disengagement Theory

Disengagement theory states that it is beneficial to both society and the individual to participate in a process of withdrawal from meaningful roles and relationships as that person enters the later years of life. While the theory does not suggest that one should sever all ties with previous acquaintances and enter a hermit-like state of existence, it does suggest that an aging individual will be less bound by the social networks in which he or she was previously engaged, and a decreased level of involvement will take place at four levels. First, the number of people with whom the individual regularly interacts will be reduced. Second, the amount of interaction he or she has with those persons will be diminished. Third, the style of interaction will be changed due to the altered status that the older individual now occupies. Finally, and most importantly, as the frequency and quality of interaction with others is diminished, the older individual will become increasingly preoccupied with his or her own situation; society will withdraw from the individual just as he or she will withdraw from society.

The roots of disengagement theory can be traced to an article published by Elaine Cumming, Lois Dean, David Newell, and Isabel McCaffrey in 1960, and a more complete description of the theory was provided 1 year later when Cumming and William E. Henry published *Growing Old: The Process of Disengagement*. Using data from the Kansas City Study of Adult Life, the authors fleshed out the details of disengagement theory by presenting nine postulates and eight corollaries. Within the postulates, Cumming and Henry asserted that disengagement is universal, though the form it takes is influenced by the culture in which one lives. In addition, the process of disengaging can be initiated by the individual or society. However, the desire of one party to disengage does not necessarily mean that the other party is willing to comply. When this occurs, the desire of society usually outweighs the desire of the individual. The authors also emphasized that disengagement varies by gender because the central role of men in society revolves around instrumental tasks whereas the central role of women involves socioemotional tasks. As it relates to the study of death and dying,

two postulates are particularly relevant. Postulate 1 emphasizes the inevitability of death, though it also acknowledges that disengaging is a highly personal experience that reflects the individual's physiology, personality, and life situation. Postulate 7 describes how the proximity of death impacts the readiness of the individual, as well as society, to disengage from one another. When the individual recognizes that death is approaching, he or she begins to curtail certain activities and discontinue selected relationships. In addition, the nearness of death leads the individual to more focused reflections on the meaning of life.

Since its introduction in the early 1960s, disengagement theory has been heavily scrutinized by a number of behavioral scientists, many of whom argue that the underlying logic of the theory is flawed and that its basic tenets cannot be adequately tested with empirical research. Nevertheless, disengagement theory has played a major role in the emergence of the multidisciplinary field of gerontology (the study of the aging process) as well as the area of life span development due in large part to the role it has played in theory development. For instance, when disengagement theory was first presented, Cumming and Henry argued that an implicit theory of aging had shaped social-scientific thought for many years without being formally stated or adequately tested. In response, the implicit theory was formalized by Robert Havighurst and named activity theory. Once in place, the theory provided the polar extreme to disengagement theory because activity theory rests on the assertion that individuals want to remain as active in later life as they have been in their middle adult years. To accomplish this, when a role or relationship is lost it is essential that another one be identified to fill the void created by the loss of the previous role. This process allows for the maintenance of one's current level of social involvement while simultaneously encouraging the expansion of his or her social network. In stark contrast, disengagement theory emphasizes that as an individual ages, he or she desires to gradually withdraw from the roles and responsibilities that were held throughout adult life. Society encourages this withdrawal because it provides the opportunity for younger individuals to occupy positions of increasing power and importance.

In addition to contributing to the formalization of activity theory, reactions to disengagement theory have led to the emergence of other theories, including continuity theory, which states that adults seek to maintain the same activities, behaviors, and relationships in later life as they did earlier in life. In order to achieve this continuity, older adults modify strategies for dealing with life events that worked in the past in order to handle the situations they face in later life. Because continuity theory is a modification of activity theory, it is also diametrically opposed to disengagement theory.

Although many scholars have been critical of disengagement theory, its role in examining how people navigate the changes that accompany the later years of life must be acknowledged. As the first explicitly stated theory of aging, it prompted the development of additional schools of thought which have greatly enhanced our understanding of the human experience.

James Knapp

See also Aging, the Elderly, and Death; Gender and Death

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Domestic Violence

The term *domestic* means the house (*domus*) or home, and domestic violence broadly refers to the sustained abuse by one person of at least one other with whom he or she is in a personal relationship. The reference to the domus suggests a distinction between public (stranger violence) and private (domestic violence). Although it is possible

to examine how often domestic violence occurs (i.e., its *prevalence*) and how often it results in death, it is important to find a way of distinguishing among different types of domestic violence.

Relationships are one of the key defining features of domestic violence. These domestic relationships are more likely to be called intimate, personal, or family relationships, and one feature is that they somehow preclude the possibility of violence through care, love, or responsibility. To explore domestic violence in more detail, it is useful to distinguish between dyadic intimate relationships, such as in marriage, and those between generations, such as between a child and parents. It is also important to consider the sociopolitical context, which is often complicit in domestic violence and also attempts to deal with aftermath and prevent further violence.

Dyadic Intimate Relationships

When considering domestic violence, people most often refer to the abuse between two adults in an intimate, loving, and sexual relationship. This could include homosexual relationships, but it is often limited to heterosexual relations where the man is abusing the woman. Indeed, many more men than women are violent in intimate relationships.

Life prevalence rates in domestic violence usually calculate how many people will experience domestic violence. Globally, lifetime prevalence for women is 1-in-4 to 1-in-5, whereas it is much lower for men at 1-in-10 to 1-in-20. More specifically, crime figures for assault show that women are usually assaulted by their partner in an intimate relationship, whereas the vast majority of men report that their attacker was a stranger.

Similar differences are seen when domestic violence leads to mortality where there are almost 3 times as many women than men murdered by their partner. For example, homicide estimates in the United States suggest that in the year 2000 there were 1,247 women and 440 men killed by their partners. Many of the men murdered seemed to have been persistent perpetrators of violence, and therefore the murder was most likely a result of self-defense or provocation. Of those—mainly men—who do murder their partner, some also kill other members of the family (familicide) and, subsequent to the murders, a large proportion also kills themselves (homicide-suicide).

Relationships Between Generations: Older Abusing the Younger

In relations between different generations, there are at least two different directions of abuse. The first is the abuse of a child by an adult, which could be an adult within their family—a parent, uncle, aunt, or grandparent—or within their family's circle of friends. The term *child* would seem to suggest that this is limited to people below a certain legally defined age threshold (16 or 18, for example), but the relationship between generations—where the younger generation needs protecting and the older generation is responsible for its progeny—seems more important because it is unlikely that passing a certain age would define certain acts as less violent. As a child is often dependent upon older generations for survival, the persistent failure to provide for a child's psychological and physical health, termed *neglect*, is a prominent aspect of understanding relationships in which the older generations abuses the younger.

Most information on the prevalence of child abuse comes from countries with monitoring systems that include, or are specifically focused on, such abuse, most of which are in the West. For every 1,000 children there can be as few as 2 children abused, such as in the United Kingdom, whereas in other countries there are as many as 12 per 1,000 as in the United States.

It is difficult to track mortality related to child abuse because the adults responsible for the child, and the child's death, are unlikely to be forthcoming about the circumstances around the death. Overall, there seem to be about two child abuse fatalities per 100,000 children every year, although estimates suggest that 50% to 60% go unreported. For example, in the United States there were an estimated 1,530 child deaths that were due to child abuse in 2006. The younger the age of the child is, the greater is the proportion of deaths caused by child abuse. Most of those deaths are due to neglect and leave no evidence of physical abuse, although many fatalities combine multiple types of abuse (e.g., physical, sexual, neglect, psychological). Perpetrators are usually young, in their 20s, of low socioeconomic status, and have experienced

abuse themselves. Again, there are gender differences, as men usually enact physical violence, whereas women are usually guilty of neglect.

The example of the Austrian Josef Fritzel is instructive. Fritzel was 73 years old when police took him in for custody in 2008. It was revealed that he had imprisoned his daughter, Elisabeth, in his basement for at least 24 years, where she had seven children by him. Police reports suggest that his abuse of Elisabeth started when she was 11; she was 42 when finally released. While this case may seem rare in how horrifying it is, it demonstrates how abuse can be perpetrated over long periods and can involve multiple forms of violence from a man that many respected.

Relationships Between Generations: Younger Abusing the Older

The second direction of abuse between generations is the abuse of an older generation person by the younger generation. This is often limited to the abuse of elderly members of the family whose advanced age is seen as making them reliant on the younger generation. In such cases, the term *elder abuse* is used, although the term can also refer to abusers outside the familial unit, such as care workers. Exploiting someone to gain access to their financial resources, referred to as financial abuse, is a prominent feature in the understanding of elder abuse.

It is important to avoid focusing solely on older adults. Parent abuse or, more broadly, the abuse of an older member of the family by a younger member, has received greater attention since the development of activist and support groups in the past decade. Adults are often seen as retaining responsibility for the behavior of the minor, however, which means that the issue of whether a minor can abuse an adult remains contentious. Indeed, in cases of parent abuse the inability of the parent to control the minor may be interpreted as neglect and therefore as abuse of the child by the parent.

It is difficult to find accurate figures on the prevalence of elder and parent abuse because it often remains hidden and receives little official recognition. As with violence in other relationships, perpetrators are usually male and perpetrators often abuse women. Estimates suggest that around 5% of those at pensionable age experience abuse, particularly psychological abuse, with slightly smaller figures (2%) for physical and financial abuse. In contrast, estimates of those who are in regular contact with people of pensionable age suggest almost double are psychologically abusive (9%), whereas half (1%) enact physical abuse. The figures for parent abuse are comparable in that almost 10% of children under 10 years old appear to be abusive toward their parents. Physical violence seems to be used more often than that of a psychological nature. Abusive children are usually considered to be severely abused and/or either severely mentally ill or dangerously antisocial.

Elder abuse has received attention only since the 1990s, and parent abuse still remains largely unacknowledged. Thus, there are few reliable studies of mortality in relation to these two types of abuse. In crime statistics, however, there is a long tradition of recording parricide, patricide, and matricide, which are the murder of a parent or close relative, father, and mother, respectively. In such figures, the terms *parent* and *elder abuse* would seem to relate to the age of the child in question, particularly whether they can be considered to be a minor that is dependent upon their parents (in parent abuse) or an adult that is independent (in elder abuse). Accounting for 1% to 4% of all homicides, parricide is relatively rare, and the majority are patricides committed by a male child. Patricides are usually limited to biological and stepfathers rather than adoptive or foster fathers. Parricides usually seem to result from relationships that are highly conflictual where it often seems that the parent is abusing the child. As with murders of men by women in dyadic intimate relationships, this suggests that the murder was a result of provocation or self-defense. Consequently, mortality figures suggest that parent and elder abuse may be underlined by abuse from the parent in question, which may be one of the reasons these are not always recognized as forms of abuse.

An illustration of abuse in relationships in which the person from the younger generation is abusing someone of an older generation is found in the patricide of Takeo Aizawa in Japan. At first, it appeared that Takeo Aizawa was murdered in 1968 by his wife. It emerged that he was murdered by his eldest daughter whom he had been sexually

abusing for over 15 years and kept in such a way that many thought she was his wife, and with whom he had five children. This case of long-term persistent abuse that was missed by neighbors and friends shows how complex the abuse in relationships can be. What at first appears to be murder in a dyadic intimate relationship is actually child abuse, and so it is possible that the abuse of older generations in domestic relationships remains hidden by other factors that seem to take precedence, such as the responsibility of older generations toward their progeny.

Future Directions

In some respects, domestic violence is no longer a contentious issue because, in many countries, it is unacceptable to openly advocate domestic violence and there is a vast amount of scholarship dedicated to exploring it. More importantly, there are a number of policy instruments in place that demonstrate the political legitimacy of recognizing and developing responses to domestic violence. For example, the United Kingdom has a policy on domestic violence entitled Safety and Justice, and Aotearoa/New Zealand has legislation devoted to domestic violence. Both of these examples, and many other policy responses to domestic violence, are linked to the UN Convention on the Elimination of all Discrimination Against Women (CEDAW), which is over half a century old and, even though it is limited to women, has been a major international instrument for dealing with domestic violence. Thus, the social supports sanctioning domestic violence are slowly being chipped away. CEDAW's focus on women, however, signals what is still contentious, and this is domestic violence's connections to deeper structural issues, particularly gender and power, which are much more difficult to elucidate. Even though most of the work advancing scholarship on domestic violence has come from feminists, there is still a reluctance to think in terms of gender as a socially constructed category that is intimately intertwined with the abuse of power. Indeed, as domestic violence is increasingly taken up by other interest groups, such as those against elder or parent abuse, the terms by which it is defined are likely to fragment, and gender will become one issue alongside a series of others.

Peter Branney

See also Familicide; Gender and Death; Homicide; Honor Killings; Infanticide

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Drug Use and Abuse

The use of psychoactive substances is a common feature of all human societies, and these drugs have been used throughout human history for medicinal purposes, pain control, religious rituals, and personal pleasure. Notwithstanding the "war on drugs" metaphor of recent decades, drug use and abuse are not problems of late modernity but rather problems from antiquity. Nevertheless, drug use and abuse take an immense economic and social toll on society in terms of society's criminalizing response to those who use and abuse these substances, the morbidities and mortalities associated with their usage, and the familial dysfunction and community disintegration common to those with addiction troubles. Drugs are viewed as a scourge on society, on morality, and on social order, and because of this viewpoint, there is a long history in the United States of battling this problem.

The terms *drug abuse* and *drug use* speak to very different concepts, although historically they

have often been conflated in the policy and public rhetoric on illicit substances, especially around the use of marijuana. A drug user is not necessarily a drug abuser. Indeed, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition,* defines drug abuse by the following four markers: (1) the failure to maintain and discharge one's role requirements, (2) the frequent use of illicit drugs in settings that are dangerous or hazardous, (3) having multiple legal problems, and (4) experiencing recurring social and interpersonal crises. On the other hand, a drug user is someone who frequently or occasionally uses psychotropic substances but is not dependent on them. Ostensibly, a drug user can give up his or her use of illicit drugs, but addicted individuals (i.e., those who abuse drugs) cannot easily accomplish this. Throughout the history of laws on drug use and abuse in the United States, there have been few attempts to differentiate between the recreational user and the everyday, freewheeling addict; this is particularly acute in discourses on marijuana use, especially where federal and state laws treat both recreational users and addicted abusers as criminals.

History

Humans have a long storied history with psychoactive plants and synthetic chemicals. The fathers of Western medicine, Hippocrates and Galen, prescribed plants with medicinal properties such as *Papaver somniferum*, the poppy flower, for a host of physical and psychological ailments, from asthma to chronic sadness. During the Industrial Revolution in Europe, laudanum, which was a tincture of alcohol and opium, was widely prescribed and used for its painkilling and healing properties. Opium was so important to international commerce that the British fought two wars, the first from 1839 to 1842 and the second from 1856 to 1860, over China's efforts to enforce Prohibition and to end British monopoly of the trade.

In the Americas, *Erythroxylum coca,* or the coca leaf, from which the drug cocaine is derived, played an important role in Inca rituals and religious funeral rites and was used for medicinal purposes. Native Americans in the U.S. Southwest and indigenous groups in Mexico employed, and continue to use, the peyote cactus and a host of hallucinogenic mushrooms in sacred rituals and religious ceremonies. The *Cannabis sativa* plant, commonly known as marijuana, has been used throughout most cultures as a medicinal, ritual, and pleasure-producing substance. Almost all human societies, including those of India, China, Africa, the Middle East, and the Americas, have a recorded antiquity with the plant, dating back to 4000 B.C.E.

The recent history of psychotropic substances in pharmaceuticals and over-the-counter products is telling. Coca-Cola soft drink was sold with cocaine until the early 1900s, and a host of mail order medicines came laced with heroin, cocaine, and opium. In fact, the Bayer Company once employed heroin as the primary ingredient in its painkilling and cough suppressant "medicines," and Smith Kline sold the "American Cannabis" brand of marijuana legally in the 1920s and 1930s before federal prohibition statutes were enacted.

America's most notable contribution to the worldwide use and abuse of drugs came in the form of the "stinking weed," tobacco. Columbus was introduced to the plant by the indigenous inhabitants of the newly discovered Americas, and it quickly spread to Europe. Tobacco was arguably the most important cash crop in colonial America as it was to the newly independent confederation of United States. In recent times, tobacco has experienced a slate of federal and state regulations on its sale, marketing, and use, and has been the source of important class-action litigation to recover monies from cigarette companies for the substantial medical costs of treating the morbidities associated with the habit. Finally, the cultivation of grapes for wine and grain for beer has been a part of human history dating as far back as 6400 B.C.E.

Prior to 1914 and the passage of the Harrison Narcotic Tax Act, the United States did not have any comprehensive federal laws prohibiting the use, manufacturing, distribution, and sale of illicit drugs, particularly cocaine and heroin. There was a patchwork of state laws and the 1909 Smoking Opium Act, which prohibited the importation of opiates, but these laws said nothing about possession for medical use or their pharmaceutical application in medicines. The Harrison Act, sponsored by Representative Francis Burton Harrison of New York, imposed a tax on the distribution of a wide range of opiate and coca-based products while

imposing strict prohibitions on how doctors could use these drugs in treating health ailments, particularly addiction itself. The Harrison Act was quickly followed by laws on alcohol prohibition between the years 1920 and 1933, the Marihuana Tax Act of 1937, and the Boggs (1951) and Daniel (1956) Acts, which increased penalties for drug use. But it was under the Nixon administration in 1970 that the United States officially declared a War on Drugs with passage of the Comprehensive Drug Abuse Prevention and Control Act. This act defined five schedules of drugs, from those with little medicinal benefit and having a high potential of being abused, to drugs like over-the-counter medications that are fairly benign. It also required the pharmaceutical industry to retain precise records on the distribution of controlled drugs and boost security for keeping these substances safe. The Comprehensive Drug Abuse Prevention and Control Act consolidated several laws on a range of illicit drugs, including anabolic steroids. Then in 1988, the U.S. Congress passed the Anti-Drug Abuse Act that led to the creation of the Office of Drug Control Policy.

In addition to the long history of statutes criminalizing the possession, usage, distribution, and sale of narcotics in the United States, there have also been noteworthy laws that have expanded treatment options for drug-dependent individuals. For instance, 1973 saw the introduction of the Methadone Control Act, which introduced the methadone maintenance treatment option to assist opiate-addicted individuals with their recoveries. In 1996, California passed Proposition 215, the Compassionate Use Act, which allows chronically and terminally ill patients to procure and/or grow medically prescribed marijuana without fear of state prosecution. And in the year 2000, Congress passed the Drug Addition Treatment Act, which allows certified physicians to prescribe narcotic substitutes for the treatment of opiate addiction, such as the drugs methadone, buprenorphine, and LAAM (levo-alpha-acetylmethadol).

Prevalence

The Substance Abuse and Mental Health Services Administration (SAMHSA), under the auspices of the Department of Health and Human Services, is the federal body charged with conducting annual epidemiological surveys on the prevalence of illicit drug use in the United States. SAMHSA surveys ascertain information on the number of Americans who are current users, that is, people who have used a substance, whether illicit or licit, over the past month.

The most recent SAMHSA survey report, *Results From the 2006 National Survey on Drug Use and Health: National Findings*, states that an estimated 20.4 million Americans were current users of illicit drugs, or about 8.3% of the population over the age of 12. These Americans used an illegal drug such as marijuana, heroin, cocaine, hallucinogens, or methamphetamine in the month preceding the date of the SAMHSA study. The survey also found that the most prevalent illicit substance was marijuana, with 14.8 million persons, or 6% of the population over age 12, using this drug in the previous month. SAMHSA data also show that about 1 million Americans used a hallucinogen, 7 million used a prescription-based psychotherapeutic, 2.4 million used cocaine, and 731,000 individuals used methamphetamine in the month prior to the survey. The results for youth between ages 12 and 17 show that in 2006, 9.8% had used an illicit substance in the previous month, down from 11.6% in 2002.

In addition to collecting information on the use of legal drugs, SAMHSA also collects epidemiologic data on the use and abuse of licit drugs, namely alcohol and tobacco. The 2006 survey of legal drug use shows that 50.1% of Americans over the age of 12 are current users of alcohol and that 6.9% of Americans are heavy drinkers, bingeing on at least 5 days over the past month. And 72.9 million Americans, or 29.6% of the population over age 12, reported they were current users of cigarettes, pipes, cigars, and/or chew tobacco.

As a whole, SAMHSA data shows that in 2006 an estimated 22.6 million people, or 9.2% of the population over the age of 12, were struggling with drug abuse or substance dependence problems as defined by the DSM-IV criteria of drug abuse, a rate that has remained constant since 2002. Not surprisingly, marijuana leads among illicit substances as the drug with the most abuse problems (4.2 million abusers) followed by cocaine (1.7 million abusers).

Besides the SAMHSA data on prevalence, the National Institute on Drug Abuse collects

information on epidemiologic and geographic trends in drug abuse through its Community Epidemiology Work Group (CEWG). This body, which has been the preeminent narcotic surveillance system since the 1970s, collects information on the abuse of six illicit substances (cocaine/crack, heroin, opiate-based substances, marijuana, methamphetamine, and MDMA [ecstasy]) from 21 standard metropolitan statistical areas across the United States, including Atlanta and New Orleans in the South, Minneapolis/St. Paul and Detroit in the Midwest, New York City and Newark in the Northeast, Phoenix and San Diego in the Southwest, and Seattle in the Northwest, in addition to other cities. The CEWG results from the 2006 survey show regional differences in, or preferences for, illicit drugs of choice. For instance, heroin abuse is particularly acute in the northeast United States, especially in the cities of Baltimore, Boston, New York, and Newark. Cocaine/crack abuse, although prevalent throughout much of the United States, is especially acute in Atlanta, Miami/south Florida, New Orleans, Washington, D.C., and Texas. Methamphetamine dependence was highest in Honolulu and San Diego, but saw increasing abuse in 2006 in the midwest metropolitan area of Minneapolis/St. Paul and in Los Angeles and Denver. And as for marijuana, it continues to lead all other illicit substances as the most frequently abused and used illegal drug in all 21 areas under CEWG surveillance.

Mortality/Morbidity

Drug use and abuse is a subject of major thanatological interest if only because of the incidences of mortality each year from the use of both illicit and licit substances. The Centers for Disease Control and Prevention (CDC) lists unintentional poisoning as the second leading cause of unintentional injury deaths in the United States, with 20,928 deaths in 2004 and 23,592 deaths in 2005. In addition, the CDC reports that "nearly all" deaths from unintentional poisoning are the result of drugs and that most of these drug-related deaths are due to the decedents' abuse of either illegal narcotics or prescription drugs. CDC mortality data for unintentional poisoning in 2004, by type of substance, shows that there were 9,798 unintentional deaths attributed to narcotics and hallucinogens (heroin, opioid analgesics, cocaine, etc.) and another 8,506 unintentional deaths attributed to other drug overdoses (sedatives, etc.). Altogether, the 18,304 unintentional poisoning deaths attributed to drug overdoses in 2004 represent an increase of 44% over the 10,295 unintentional drug overdoses in the year 1999. The aforementioned statistics mainly represent reports on illegal narcotics. The mortality figures for lawful drugs are much more pronounced.

In 2006, 418,000 deaths were attributed to the use of tobacco products, mostly from malignant neoplasms, cardiovascular disease, and respiratory disease, making tobacco consumption the leading cause of preventable death in the United States. On the other hand, the CDC reports that excessive alcohol consumption is the third leading cause of preventable mortality, with about 80,000 deaths per year that are alcohol-attributable deaths, that is, morbidities such as alcoholic cirrhosis of the liver, ischemic heart disease, and liver cancer. Moreover, alcohol-related traffic fatalities account for nearly 40% of all vehicular deaths in the United States, close to 17,000 deaths each year.

The incidence of morbidity associated with drug use and abuse varies by the type of drug in question and the mode and pattern of use or abuse. Some drugs and modes of use carry significant risk of illness, not to mention death. Heroin, above all illicit drugs, is associated with some of the most life-threatening viral morbidities. Heroin use and abuse typically begins with addicts snorting the drug and only later proceeds to the intravenous mode because of the intense "high" associated with injection drug use. However, once the mode of use changes from nasal ingestion to intravenous injecting, morbidity and mortality risks dramatically increase.

Epidemiological surveillance on injection drug users finds that HIV/AIDS, hepatitis C, and hepatitis B continue to afflict this population in disproportionate numbers, largely because of the sharing of hypodermic syringes among opiate-addicted individuals. Injection drug users accounted for 14% (5,292) of the 37,164 newly diagnosed HIV infections in 2005. CDC statistics report that 50% to 80% of heroin addicts will become infected with the hepatitis C virus within 5 years of the start of their drug use, and hepatitis C virus is a major contributor to liver cancer and cirrhosis.

Accordingly, blood-borne and other infections, such as bacterial pneumonia, skin infections, and endocarditis, are morbidities that too often result from the sharing of used needles.

Given the serious risks of morbidity and mortality associated with injection drug use, it is startling that more needle exchange programs are not in existence across the United States. Intravenous drug users share because of the scarcity of available clean needles. One approach to reducing the high rates of HIV, hepatitis C virus, hepatitis B virus, and other viral and bacterial infections that afflict drug users and abusers is to encourage needle exchange programs in areas where the intravenous mode is high. But although the epidemiological evidence suggests that needle exchange programs work in reducing viral infections commonly associated with injection drug use—and even though the CDC has called, since 1997, for reform in syringe laws to remove the legal barriers that prevent needle exchange programs from operating—the U.S. federal government refuses to fund these programs. As of 2006, there were 185 needle exchange programs in the United States, but many were illegal and all were operating without federal funding.

Treatment

SAMHSA reports that in 2006, 4 million Americans, age 12 and older, received treatment for a drug-related problem. Moreover, alcohol was the most common drug for which individuals sought treatment, with some 1.2 million receiving treatment for alcohol abuse and 1.6 million receiving treatment for a combination of alcohol and illicit drug abuse. Once the decision has been made to seek help for drug abuse, affected individuals have several treatment options: (a) detoxification and rehabilitative therapies, (b) substitution treatments, (c) private doctor's office, and (d) self-help support groups, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA); the last of these is the most common treatment option.

The medical model of drug use and abuse presupposes that addiction is a disease and, as such, is a condition that can be medically treated. But under the medical model, arguments continue about whether drug addiction should be treated as a chronic condition, with appropriate pharmacological interventions to manage cravings, or whether substance abuse should be seen an acute, or temporary, condition that should be assuaged with detoxification, group counseling, and rehabilitative therapies. Consequently, there are two competing paradigms on drug addiction which encapsulate this debate: the harm reduction and the demand reduction approaches to drug abuse treatment.

Advocates of the harm reduction approach generally ascribe to the view that the primary focus of treatment should be on reducing the negative effects of addiction, such as the high rates of viral and bacterial morbidity and mortality associated with injection drug use. The best exemplar of this approach is substitution treatment. Substitution is an approach whereby the addict is given a pharmaceutical substitute to replace his or her illicit drug of choice. Under substitution treatment, an addict might also receive counseling in the form of group and individualized therapy. Substitution treatments usually employ a synthetic pharmaceutical such as methadone, buprenorphine, Suboxone (high-dose buprenorphine), or naltrexone that blocks the effects of the drug on the brain. While on these substitutes, the addict will not be able to experience the euphoric sensation that heroin has on the brain's pleasure receptors.

The most common substitution therapy in the United States is methadone maintenance treatment; about 110,000 individuals receive daily doses from methadone clinics. Another substitution therapy is heroin maintenance, whereby opiate-addicted individuals receive a "daily dose" of pure heroin administered by a clinician. A few heroin maintenance programs exist in Germany and the Netherlands, but the vast majority of European programs, for their 300,000 substitution patients, administer a synthetic pharmaceutical. Finally, another type of harm reduction approach is the needle exchange program, whereby opiate-addicted individuals can exchange dirty needles for clean ones without fear of arrest and prosecution.

Advocates of the demand reduction treatment approach, by contrast, tend to favor strategies that stress rehabilitation in conjunction with complete detoxification and sobriety. Demand reduction treatments usually require a period of detoxification followed by rehabilitation therapy that typically involves individualized and group counseling and encourages participation in a sobriety

commune, like Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). The demand reduction approach, especially as advocated by NA and AA, sees recovery as a perpetual state wherein the addict must be forever vigilant against falling back into drug use and abuse behaviors.

Some advocates of the demand reduction approach, which is favored by U.S. policymakers, see substitution treatments as simply substituting one addiction for another, since drug-addicted individuals frequently become dependent of these pharmacological substitutes, especially methadone. Other demand reduction supporters believe that harm reduction therapies, such as needle exchange programs or heroin maintenance, enable and encourage bad behavior.

Drug use and abuse are intractable problems in society with no clear solution in sight. The thanatological importance of this subject is profound and unassailable given the level of morbidity and mortality from drug use.

Lee Garth Vigilant

See also Acute and Chronic Diseases; Alcohol Use and Death; HIV/AIDS; Psychological Autopsy; Subintentional Death

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DUELING

Dueling is a ritualized form of combat used to settle an honor conflict between two individuals. In Western societies, key elements in a duel often include the original offense to a person's honor, or social reputation; the use of seconds, or witnesses, in the communication between the offended parties; and the ceremony of the duel itself, often facilitated by the seconds and where participants select arms and subsequently engage in brief, organized combat. A duel has concluded when blood has been shed, when one of the participants is too wounded to continue, or when someone has died. Although this more ritualized form is rarely practiced today, dueling has become a common term denoting competition for dominance between two individuals or parties. The triumphant party acquires vindication or fame. Failure to participate leads to social death as a result of the loss of honor or reputation. In addition, vestiges of the duel emerge in contemporary culture in the form of fights between individuals or groups seeking dominance, the restoration of their reputation, or revenge. Examples of this include gang conflicts or honor killings.

General Dueling Scenario

In general terms, a duel arises through the following process. An individual suffers an insult to his or her honor. Offenses may be verbal, such as an implication of cowardice for a man or impurity for a woman, or physical, such as tugging on a man's beard, slapping him in the face, or seducing a woman in his family. Once the insult has occurred, the offended party issues a challenge demanding satisfaction through a duel. The other party faces high pressure to accept this challenge or risk being viewed as a coward by society. Because duels are often illegal but socially accepted, participation in one shows that both parties value their honor more than

the law and even their lives. Once the challenge has been accepted, both parties agree upon a time and place to meet for a clandestine combat. The seconds serve as representatives for the offended parties in all communication and also participate in the dueling ceremony, which includes selection of equal weapons. Depending on their selection of weapons, participants may engage in a sword fight, exchange shots with pistols, or use some other type of combat. Once the duel has concluded—that is, when one member sheds blood, becomes too wounded to continue, or is dying—honor is restored for both parties.

History of Dueling

The modern duel's origins have been traced back to the Middle Ages after the fall of the Roman Empire with the emergence of its antecedent, the judicial duel, or trial by combat. V. G. Kiernan notes that the development of the judicial duel occurred in the context of a feudal society. The high level of competition among nobles led to disputes among groups, and trial by combat offered an alternative to acts of revenge or large battles between these groups. Elements from the modern duel, including the issuing of a challenge and the selection of weapons, appear in the judicial duel. In addition, the phrase "throwing down the gauntlet," or challenging an opponent, appears during this time. It was believed that the outcome of the judicial duel was determined by divine intervention, and the guilty party would either die in battle or, upon losing, would face additional punishment.

Initially approved by kings and other rulers to settle legal disputes, the duel eventually encountered opposition from the Catholic Church and, later, civil authorities. Both viewed the duel as a threat to divine and legal authority. Nonetheless, dueling continued and morphed from the joust of knightly Europe into the clandestine duel of honor during the Renaissance.

With the duel of honor, the use of armor and horses was discarded, and participants stood on their own two feet, wielding simpler weapons, such as swords and (later) pistols. Rather than fight in a tournament before a crowd of spectators, duelists met in secret locations, often at dawn, to settle their disputes, because dueling had become illegal in many places. During the late 15th century the conditions for settling disputes with dueling began to be written down in honor codes. Girolamo Muzio's *Il Duello,* published in 1550 in Venice, is one of the more famous codes, and the term *duel* is adapted from the Italian, which originated from the Latin word for war: *duellum*. Treatises described the types of offenses that justified dueling as well as various regulations for dueling ceremonies, such as the selection of weapons and who could stand in if a participant was unable to fight.

Dueling proliferated throughout Europe during the 17th century, in part due to the influence of the Thirty Years War from 1618 to 1648, despite ecclesiastical and legal opposition. Laws prohibited dueling and even mandated that it be punishable by exile or death, though enforcement was inconsistent at best. Dueling's prevalence extends to literature, especially in plays by Spanish authors such as Lope de Vega and Calderón de la Barca (1796).

Although the number of duels fought decreased during the 18th century, its influence continued in culture. For example, dueling appeared in novels such as Samuel Richardson's *Clarissa* (1747–1748) and Pierre Choderlos de Laclos's *Les Liaisons Dangereuses* (1782). However, the French Revolution of 1789 regenerated interest in the practice of dueling and also democratized it. Members of the aristocracy continued to use the duel to settle disputes, but an increasing number of members of the military and middle class also participated.

During the 19th century, dueling initially increased in action and cultural representation in Romantic literature. In the United States, dueling acquired a more public flavor, and many duels had spectators. The most famous duel in U.S. history occurred in 1804 when Alexander Hamilton was killed by Aaron Burr. Dueling first fell out of favor in the North, but continued to be associated with Southern culture. By the end of the 19th century, duels were rare in both Europe and the United States, though isolated examples continued well into the 20th century.

Implications for Contemporary Culture

Although duels of honor are now rare, their influence in contemporary culture appears in

numerous ways. The notion of dueling as a contest for fame or dominance between two parties often emerges in various competitions during which opponents face each other one-on-one. In addition, revenge killings, occurring outside the sphere of the law, reflect a compulsion to attain satisfaction for an offense. John Grisham's *A Time to Kill* (1989) centers itself around such a situation. Such behavior suggests that many value honor more than the law or their own lives, because they believe a physical death is more tolerable than a social death.

Kristie Niemeier

See also Honor Killings; Literary Depictions of Death; Lynching and Vigilante Justice; Popular Culture and Images of Death; Social Class and Death

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Economic Evaluation of Life

The economic evaluation of life encompasses the costs associated with death, the amount people and governments pay to reduce risk of death, and the appropriate compensation for wrongful death. Costs associated with death are an accounting after the fact, often one restricted to tangible costs that ignore quality-of-life loss. The amount paid for risk reduction mirrors the value placed on death before the fact. Compensation for wrongful death is driven by deterrence, providing incentives to be diligent with other people's lives. It is constrained by widely varying state laws. This entry excludes the topic of life insurance, as it is not a valuation of life. Rather, life insurance shows how much money risk-adverse families and businesses choose to invest to ensure survivors will be able to meet their financial needs if someone dies. Some people also buy life insurance to impose discipline on their effort to provide an inheritance. Thus, life insurance purchasing does not reflect how people intrinsically value their lives.

Costs Associated With Death

Death imposes costs on survivors, employers, and governments. The venerable method of valuing these losses was stated by Adam Smith in his 1776 classic *Wealth of Nations*: A man is valued by what he produces, his *human capital*. In practical terms, that meant people were valued by what they were expected to earn during their remaining life span. Over time, that definition expanded to include the value of household work such as cooking, cleaning, maintenance, yard care, and child care. Direct costs were added for emergency services, such as police, fire, and emergency transport; medical treatment prior to death; investigation of fatal incidents; coroner and medical examiner services; and funerals, as well as employer costs to hire and train replacements for deceased employees.

Despite those expansions, human capital costs have severe limitations. They lack a theoretical basis. They fail to value pain, suffering, lost quality of life, loss of consortium and companionship, and loss of unique skills. They place minimal value on retired people, and because of wage discrimination, they undervalue women and minorities relative to white males. Men, for example, earn 25% more than do women in comparable jobs.

Value of Risk Reduction

Basing public policy choices on a method with such obvious gaps and biases is not appropriate. In the 1960s, a new economic paradigm emerged when Jacques Dreze and Thomas Schelling suggested that policy analysts should value a person's life based on the amount the person was willing to pay for a reduced probability of dying.

Unavoidably, everyone takes risks. But most individuals view life as sacred and willingly spend large sums to save people whose lives are at risk. Search and rescue operations, space shuttle fail-safe measures, and heart transplants are viewed as heroic measures, regardless of their cost. Although

policymakers recognize this view, they need to make decisions about anonymous lives and daily risks. Economists assume people behave rationally in response to the risks they perceive and understand the consequences if risk taking leads to illness, injury, or death. With those assumptions, risk behavior reveals the value of risk reduction. Assuming rationality prevails, risk reduction values show how people value preventing deaths.

Challenged by Schelling, economists developed values. Some asked people what they were willing to pay for risk reduction. Others analyzed risk reduction markets. All began to probe (a) the extra wages paid to induce people to take risky jobs; (b) the demand, price, and perceived effect on risk of bicycle helmets, smoke alarms, cigarettes, and other products that affect health and safety; or (c) the trade-offs people make between time, money, comfort, and safety (e.g., in choosing how fast to drive on an open road). These analysts learned what people actually pay for small reductions in their health and safety risks. Actual payments are more concrete and more credibly measurable than survey responses about what one would be willing to pay, yet they are equally acceptable from a theoretical viewpoint.

The values were named *willingness to pay,* which is so nebulous that it raises immediate doubts about the method for most people. Summing people's risk reduction payments, economists compute what a group actually pays, and therefore is willing to pay, in the expectation of saving a life (e.g., what 10,000 people pay for a 1 in 10,000 reduction in fatality risk)—the *value of statistical life* or, stated in another way, the value of an anonymous life.

More than 100 studies have assessed anonymous life values, providing more than 250 estimates. Systematic reviews of the values suggest they vary with income. Calculating the best estimate for 2008, for example, suggests the value of an anonymous American was approximately $6 million. The credible range is from $5 million to $8 million.

Quality of life dominates anonymous life values. Lost wages and household work account for only one sixth of the total. Although one fourth of all medical spending typically occurs in the last year of life, medical expenses average about 1% of fatality costs.

Anonymous life values are family values. Spouses, parents, even children influence safety belt use, speed choice, and decisions about high-risk employment. Because the value of an anonymous life is a family value, it excludes costs compensated by government and insurers—lost taxes, wage replacement, and most direct costs. Those exclusions total less than $500,000. Public valuation of an anonymous life would add these costs to the family value.

Individual Versus Statistical Lives

These values should be cast in the context of Broome's paradox: Widely accepted risks that would result in anonymous deaths are not acceptable if the lives at risk are not anonymous. With a known life, not only do the individual's attributes become relevant but emotion may overwhelm rationality. As Schelling observed, avoiding the death of a particular person is not simply a market transaction. Guilt, social responsibility, morality, and religious beliefs come into play once the person who would die is known. Personal characteristics and relationships also gain relevance.

Partially due to Broome's paradox, assuming the value of risk reduction and the implied value of an anonymous life, revealing the cost of deaths that already have occurred is controversial. Rationality demands variation in values between individuals. Scoundrels should be valued less, saints more. People's views of, experiences with, and valuations of an individual may differ radically, muddying the person's value from a societal viewpoint. Moreover, 100,000 one-in-a-million risks of death may be valued much less than a one-in-ten risk of death. As certainty nears, the threat becomes more tangible and avoidance rises disproportionately in importance; the value of an anonymous life, thus, represents a lower bound on the postevent value placed on the average decedent.

Risk Reduction Decision Making

Sound public policy on health and safety requires comparing the costs and savings from intervention and trading off risks. Implementing every conceivable protection is unaffordable. It also is economically inefficient. For example, the U.S. Department of Labor's 1987 standard on occupational

exposure to formaldehyde cost $400 million per life saved. That expenditure diverted funds that firms and their workers would have spent on other things, including health and safety measures with a lower cost per life saved. Research suggests that $20 million to $25 million in government-mandated or direct government spending on risk reduction costs someone his or her life. Sometimes implementing a risk reduction measure also directly increases other risks. For example, road improvements to improve safety can cause fatal construction-related crashes. Decision analysis should weigh all the risks and benefits.

Compensation for Wrongful Death

Regulatory decisions value death differently than does the tort system. The law primarily compensates individuals for their losses. If compensation for wrongful death were only for the sometimes minimal losses of surviving family, it would be much cheaper to kill someone than to maim that person. States address this moral hazard. Some states allow compensation to the estate, standing in place of the deceased. Others prescribe what compensation is due to survivors. The categories of damages that may be compensated vary, and the methods of computing these damages sometimes are dictated. Courts impose additional computation rules. In the courts, compensation for lost quality of life computed from the value of an anonymous life is called *hedonic damages*. The first hedonic damage claims were made in the mid-1980s. They are gaining some acceptance, but many states disallow them.

Because wrongful death compensation is bound by legislative fiat, studying these awards does not reveal the costs associated with death. Analysts interested in juries' willingness to award instead study the value of an anonymous life used in compensating nonfatal injury. Excluding punitive damages, they are able to explain 22% to 38% of the variation in jury awards based on the percentage of quality of life lost. Adding other explanatory variables—such as age, gender, contributory negligence, whether the defendant had deep pockets, and whether experts were used—raises explanatory power above 50%. Willingness to award ranges from $3 million to $6 million per life lost. It is higher for assaults and injuries caused by drunk drivers than for unintentional injuries caused by consumer products.

Ted R. Miller

See also Economic Impact of Death on the Family; Legalities of Death; Life Insurance; Quality of Life; Wrongful Death

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Economic Impact of Death on the Family

The economic impact of death can largely be described in terms of life insurance needs. Life insurance policies provide financial resources to absorb the economic shock to surviving families. Depending on the family situation, the purchaser of the life insurance policy, usually an income provider, identifies the financial needs of their surviving family and loved ones in the event of the income provider's death. Life insurance pays death benefits to those who were financially dependent on the deceased to cover income replacement, final expenses, readjustment-period needs, debt repayment, college-expense needs, and other special needs. Final expenses occur immediately before or after death. The readjustment period is the time needed by the surviving family to adapt to the physical and, in the case of an income earner or provider, the financial void caused by the death of a loved one. In

general, the need for life insurance decreases as families get older and assets accumulate over the life course.

This entry describes the loss of income at the death of an income provider, final expenses, readjustment period, and other unmet financial obligations of deceased providers. Coping strategies in the financial life cycle and other death benefit programs—such as prepaid funeral arrangements, burial societies, and welfare programs—are also discussed. The customary practice of wife inheritance in Africa, which was designed to ensure widows and surviving children are provided for economically, is described as an example of cultural differences in strategies and programs used to mitigate the economic impact of death.

Loss of Income

Upon the death of an income earner, the immediate impact is the loss of income. Life insurance planners estimate that, to maintain the same living standard, survivors need to replace about 75% of the deceased's after-tax annual income, as the family's expenses are reduced by 20% to 25% due to the death of that family member. Surviving spouses and partners must adjust to income loss over a period of time, which varies depending on the circumstances of the death (whether the death was anticipated or sudden) and the survivors' economic dependency (whether the survivors are partially or solely dependent on the deceased's income).

In the final stage of life of most retirees, there is no regular income from paid or self-employment. Retirement savings, investments, and insurance policies (such as health insurance and long-term care) provide resources for later life and the end of life, but if death is premature, these reserves are often inadequate to absorb the economic impact of death on the family. Younger families need to avoid tapping into such assets because they may be needed for special goals such as college expenses or the retirement income of a surviving spouse. The temptation to use these funds is greatest when there is no life insurance policy. Funds held by the deceased in savings accounts, investments, retirement plans, and pensions can be used to pay for final expenses and readjustment expenses.

Final Expenses

Final expenses, usually comprising burial costs, occur in the event of any death, whether of an income provider, dependent, or a young child. Obvious pre-death final expenses include uninsured medical expenses for terminal illnesses. Medical expenses for deaths attributed to illness or injury comprise out-of-pocket payments for uninsured health care, deductibles, and copayments. Burial costs include the professional services of the funeral director and other staff for visitation and graveside services and transportation, embalming, burial clothing, and other preparations of the body. Other funeral costs include the casket or cremation urn, the tombstone, rental of facilities, floral arrangements, travel, accommodation, and food. "No-frills" funerals cost about US$10,000; cremations cost less.

Readjustment Period

In the readjustment period after the death of an income earner or adult, surviving family members develop strategies to become self-reliant, to manage the household, and to live within their reduced financial means. This period can last a month or several years, depending on the family situation. Longer readjustment periods are typical when death is unexpected, if surviving partners are unemployed, or if there are young children. Survivors may need to obtain education or training before entering the labor force. Some survivors have to work part-time or stop working to care for minor dependents. Households that have experienced premature adult death tend to allocate more time to child care, which could mean reduced working hours and reduced wages for working survivors. It has been found that in most households where there has been a death of an income provider, there is a decrease in the average daily time for nonfamily productive activities, especially among the higher educated. However, child care costs can also increase in families in which the deceased was employed and the other parent, who previously stayed home to care for the children, now has to work outside the home. Other family members may use the readjustment period to receive counseling to cope with the loss, especially if it is an unexpected loss or the loss of

a young child. Counseling costs are therefore also a consideration for some survivors.

Financial Obligations of Deceased Providers

Debts are not written off by the death of the borrower. Mortgages and car loans must still be paid by co-borrowers or through the dissolution of the borrower's estate. Unpaid credit card balances and other loans must be paid off or settled. Unmet education loans of the deceased, spouse, and/or children must also be paid. The economic impact of death can also affect the future needs of survivors because the death of a provider is also the loss of future income or savings to pay for college expenses for surviving children, spouse, or both. Other special needs may be required, such as extra coverage for wealthier families who have to pay estate and inheritance taxes, or medical needs for dependents with chronic medical conditions.

Coping With the Economic Impact of Death and the Financial Life Cycle

Several coping strategies are adopted by households and families to mitigate the economic impact of the death of an income provider. Across all income groups, researchers found significant reductions in savings and investments by affected households. Lower-income surviving families are more likely than are wealthier survivors to reduce expenditure on consumer durables and sell assets to raise or supplement income. Some families may increase their debt burden if they have open lines of credit, such as home equity and credit cards, which they may use to cope with living expenses after the death of a provider, especially if life insurance assets and death benefits are inadequate or not available.

In their life cycle hypothesis, Ando and Modigliani proposed three stages of an ideal or typical individual's financial life cycle. During the first stage, individuals accumulate human capital in the form of education and training in anticipation of higher income. Once education is completed and employment begins, in the late teens or early 20s for college graduates, the financial life cycle really begins. The first stage can be decades long and centers on the accumulation of wealth in the form of increasing income, with career experience, and the accumulation of assets. Goal setting, income protection and insurance of assets, home purchases, and family formation get the spotlight in terms of financial planning.

During the second stage, which for some people may begin in their early 50s, financial goals shift to the preservation and continued growth of accumulated wealth. The highest income or peak of an individual's career usually occurs in this stage. Estate planning may become a consideration for those who wish to pass wealth to their heirs. The third and final stage is retirement, which typically begins in the mid-60s. From retirement until death, an individual spends and "dissaves" accumulated wealth, particularly retirement savings and investments. *Dissaving* means that one spends more than one earns, as one lives on retirement savings and investment income.

A criticism or complication of the life cycle hypothesis is that it fails to account for inheritances and bequests as part of an individual's financial life cycle. Households place value on consuming a portion of their accumulated wealth while alive, bequeathing the remainder upon death. In addition to final expenses, the settlement of the deceased's estate, in the absence of a will, is estimated to cost 4% of assets. Survivors and beneficiaries must consider additional costs of inheritance taxes.

Other Death Benefits Programs and Post-Death Arrangements

In addition to savings and life insurance assets, employer accidental death benefits and government and welfare benefits provide financial resources to absorb some of the economic impact of death. In the United States, Social Security taxes paid by workers provide death and survivor benefits to primary beneficiaries after the worker's death through Old Age, Disability or Survivors Insurance (OADSI or OASI). Death benefits are given as monthly annuity payments or as a lump-sum death payment to surviving spouses and children under the age of 18, or up to age 22 if those children are students. Lump-sum payments from OASI benefits can also be sent directly to funeral homes for funeral expenses. Supplemental Security Income is available to those who do not qualify for OASI benefits or have a small amount of OASI

benefits. Surviving parents, relatives, or kinship caregivers may apply for financial hardship benefits to support qualifying children of the deceased through the Temporary Assistance for Needy Families program.

Most developed and increasing numbers of developing countries have similar welfare models as well as employer-sponsored accidental death benefits. In collective societies, particularly in developing countries, family and community groups contribute to burial expenses. In some African traditions, clothing and other material property not protected by a will or probate system are gathered and distributed to survivors by elder relatives. Traditionally, surviving dependents are adopted by extended families or the community, and a surviving wife may be "inherited" by the deceased's surviving male relative chosen by elders as fit to provide for her and any surviving children. Most widows accept this arrangement as a way to keep their children and property.

It is more common nowadays to prepay funeral expenses by purchasing burial or funeral insurance policies or guaranteed pre-need arrangements, thus locking in today's funeral prices. Burial societies are common too, particularly in developing countries. These are nonprofit social organizations to which members pay voluntary contributions for the payment of funeral expenses upon their death or the death of a family member. This preparation for death, just like life insurance planning, helps eliminate the financial stress of surviving family members.

Conclusion

The economic impact of death varies with family structure and the economic circumstances of survivors: whether or not the deceased was an income provider, if the deceased had life insurance, and what the ages are of the deceased and the surviving family. Life insurance planning may mitigate income loss, the burden of final expenses, and the long and difficult readjustment periods for younger families and hence help prepare families for the premature death of an income provider, but the U.S. Survey of Consumer Finances showed only a modest impact of life insurance on survivors' financial vulnerability. The diminished living standard after the death of a loved one is more significant for uninsured surviving women than it is for uninsured surviving men. Further, the data revealed that the financial vulnerabilities of the uninsured were widespread across the whole life cycle, that is, for all age groups of survivors.

Older families do not need to purchase life insurance to prepare for the economic impact of death. They are adequately prepared for the final expenses and living expenses after the death of a deceased provider if they have accumulated reserves in retirement plans, pensions, savings, and investments, according to the ideal financial life cycle. In addition, older families typically would not be supporting dependents and would have paid down significant debt burdens.

Sophia Anong

See also Burial Insurance; Economic Evaluation of Life; Estate Planning; Inheritance; Life Insurance; Pre-Need Arrangements

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Egyptian Perceptions of Death in Antiquity

The Giza Pyramids, the only remaining example of the Seven Wonders of the Ancient World, are massive tombs that demonstrate the emphasis placed on death and the afterlife by the ancient

Egyptians. Life in ancient Egypt was, as noted by Thomas Hobbes, "brutish and short." The ancient Egyptian beliefs regarding death are complex. The focus was not on the end of life but on the cycle of life, which encompassed such issues as sex, fertility, death, and rebirth, and potentially immortality. But the ancient Egyptians prepared in life for a more pleasant existence in the afterlife, an afterlife that promised an easier existence than that experienced while living.

Because of the burial practices in Predynastic Egypt (c. 5500–3100 B.C.E.), such as funerary goods, it is assumed the ancient Egyptians held a complex set of beliefs regarding the afterlife. Given the typical items found in these early graves, it is clear the Egyptians believed one would need these items in the afterlife.

During the Predynastic era, Egyptian bodies were buried in the fetal position; this practice implies a belief in rebirth after death. The scarab beetle (aka the dung beetle), which hatches in a ball composed of mud and dung, appears throughout ancient Egyptian literature as a theme that links notions of death and rebirth. This link with life, death, fertility, and rebirth are common features throughout Egyptian practices. Some funerary texts dating from the Middle Kingdom (c. 2030–1650 B.C.E.) describe the *ba* (the living, immortal divine soul) of the dead man engaging in sexual activity with goddesses and mortal women.

The practice of mummification is thought to have developed after bodies that had previously been buried in the desert emerged in a preserved state. Discovery of these preserved bodies may have aided the ancient Egyptians in developing the concept that the dead continued to live and that the physical body was needed to maintain existence in the afterlife.

To ensure this continued existence, statues of the deceased were often interred with the person's body. Another method to ensure existence after death was via the name, or *ren*, of the deceased person. In instances when it was thought an individual had betrayed the interests of Egypt, that individual's name was physically destroyed by eliminating appropriate writings and inscriptions, along with the destruction of that person's physical body and images thereof. One such example of an attempt to thwart an existence in the afterlife is that of Akhenaten (c. 1349–1336 B.C.E.), a pharaoh who ruled during the Eighteenth Dynasty (c. 1550–1295 B.C.E.). Akhenaten was unsuccessful in attempting to replace ancient Egyptian religion with monotheism. In this instance at least the attempt was not totally successful given that some information remains.

Related to the concept of the afterlife are the *ka*, *ba*, and *akh*. The ka is commonly translated "spirit," like a spiritual doppelganger; ba is thought to be associated with one's personality of moral qualities akin to a soul; akh is held as the successful reunion, at death, of a person's ka and ba, somewhat like a shadow. If a person's ka and ba were not reunited and akh failed to develop, then everlasting life would not occur. In essence that person would be condemned to eternal death.

In the ancient Egyptian religion, the opposite of paradise or Hatep (meaning offerings) was not hell or misery but rather the absence of existence. In addition to ka, ba, and akh, two additional elements required for one to be remembered and protected after death were a person's name and shadow.

Ancient Egyptians believed they would experience judgment upon their death in a ceremony known as Weighing of the Heart. The ceremony was thought to occur in the presence of Osiris, the chief god of the dead. The deceased was required to name each of the deities present and to swear in oath that none of the long list of offenses described had been committed during his or her lifetime. Along with professing their innocence was the ritual of placing the deceased's heart on a scale opposed by a feather which symbolized *ma'at*, the ancient Egyptian concept of truth and justice. If the heart balanced against the feather, the procession was permitted to continue. If the deceased's heart was heavier than the feather (believed to occur because of that person's lifetime transgressions), the heart would sink on the scale and be devoured by "the gobbler" Ammit, an animal with the head of a crocodile, the torso of a lion, and the hind end of a hippopotamus.

The heart was held to be the focus of thought and emotion and was, therefore, considered the most important organ. Given its critical role in one's existence, the heart was not separated from the body during the process of mummification. However, the brain was not considered to be valuable, and thus it served as packing for the head. During mummification, the brain was removed and discarded.

Ancient Egyptians believed that writings and illustrations held magical properties. The Book of the Dead, a collection of approximately 200 magical spells, offers a roadmap into the afterworld. Those individuals able to afford to do so included various parts of the Book of the Dead among the burial artifacts. One example of a more popular spell prominent in a person's burial is chapter 125, which outlines and portrays the Weighing of the Heart as having a favorable outcome for the deceased. Even though some of the spells would nearly ensure successful passage into the afterlife, the Book of the Dead sections were expensive, so most common Egyptians could not afford to make such as purchase.

Mummification

The preservation of the body was considered as being vital for continuation of existence in the ancient Egyptian afterlife. Even though many analysts believe that the first mummies were naturally occurring, it is clear that steps were taken at a later time to improve bodily preservation. The oldest Egyptian example of human attempts regarding bodily preservation dates from the Fourth Dynasty (c. 2575–2551 B.C.E.) with Queen Hetepheres, the mother of the pharaoh Khufu, who is thought to be the builder of the Great Pyramid. Some of her internal organs were removed, embalmed, and buried separately from her body.

Variations in mummification practices are noted throughout the period of ancient history including examples such as the use of blue beads to cover mummies from about the Twenty-Fifth Dynasty onward. But the basic procedure for mummification remains unchanged.

The entire mummification process took 70 days. First, the deceased's body was purified; usually this occurred along the west bank of the Nile because of properties associated with the Nile River. The body was washed in a salt solution mixture known as natron, which aided in the dehydration process vital in mummification. The embalming process included removing the internal organs, which were individually embalmed and placed into Canopic jars. From the Twenty-First Dynasty onward, these organs were then placed back into or around the body. The body was stuffed with temporary packing material and covered with natron for a period of 40 days, after which the body was uncovered, the stuffing was removed, the deceased's body was rinsed inside and out, dried, and repacked with linen, resin, natron, and other materials. In the Late Period (712–332 B.C.E.), bodies were often completely filled with resin. The body was rubbed with a variety of substances—such as natron, beeswax, wine, and spices—and cosmetics and other aesthetical effects, such as rouge, were applied to the body. Amulets to provide protection were placed in various locations on the body. A coating of resin was then covered over the body to further enhance preservation. At this point, the 15-day process of bandaging was begun.

The bandaging with 450 square yards of linen was a common practice. The process included rituals, such as spells, recited by priests and placing jewelry items in the separate layers. A bandaged body was covered in one or more shrouds and placed in one or more containers. The type, elaborate nature, and quantity of the containers varied depending upon the wealth of the deceased. In the case of royal individuals, mummies were usually placed in gold coffins.

Funerals

Funeral scenes were a common feature of paintings found in the tombs of ancient Egyptians. Expensive funerals and the extent of the lavish nature of these funerals depended on the status and wealth of the deceased. The mummy was placed in a shrine-like configuration and surrounded by bouquets of flowers. For the procession of the body from the embalmer to the tomb, the body, encased in a shrine-like container, was placed on a boat-shaped bier and onto a sled. The Canopic jars holding the deceased's internal organs followed behind the body. Priests walked in front of the body performing rituals such as the burning of incense, while food and other items accompanied the body during the procession. Mourners were viewed as a critical part of the funeral ritual, and if enough funds were available, professional female mourners, who tore their hair, cried, rubbed themselves with dirt, and ripped their clothes, were hired.

Dancers represent another common feature of the funeral procession. Women had a prominent role to play in mourning; men, on the other hand, were more reserved.

Priestly rituals performed during the funeral, such as the "opening of the mouth," were included to ensure the body contained the ka during the afterlife. Ceremonies also had to be performed on any statues of the deceased so that they could serve as vessels for the ka if needed. After the burial, guests would partake of a feast.

Most ancient Egyptians were buried in underground graves and raised platforms. Burial site security was of concern given the importance placed on the preservation of the body. Elaborate tombs, such as the Great Pyramids, are a sign of the importance placed on the cycle of life; these also serve as a signal to where great wealth is housed. The vast majority of elaborate tombs were ransacked long before Egyptologists began cataloging their contents. One of the most famous Egyptian discoveries, the tomb of Tutankhamen ("King Tut"), held one on the largest caches of goods found in modern times. The lack of external ostentation of the tomb hid the fact a tomb was present. It is ironic then that the desire to display one's wealth, in essence, ensured that that wealth would be removed and, in fact, would lead to the destruction of the body, which was thought to be vital for continued existence.

In conclusion, death was a central focus of Egyptian culture. Within ancient Egypt, death was viewed not as the end of life but as part of the life cycle. Many aspects of Egyptian culture, such as religion and commerce, paid considerable attention to death, grieving, and the afterlife, all of which seem quite different in comparison to modern practices. Other elements, however, such as partaking of a feast after burial, are quite similar to what is common in modern times.

Janet Balk

See also Ancient Egyptian Beliefs and Traditions; Immortality; Mummies of Ancient Egypt

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Elegy

Elegy refers to a particular pattern of poetry that addresses topics such as love, longing, and mourning; more often, elegy encompasses a variety of formats that address death and dying. The death-related elegy is the lyrical approach to loss and grief. Sorrowful lamentation, idealization of the deceased, and provision of solace are among the elegy's identifying traits. Though they vary across cultures and eras, elegies commonly convey mourners' melancholic emotions, memories, and struggles to grasp meaning from the demise of their beloved. They may be written for and about the dead, on the nature of death and life, or in anticipation of one's own expiration. Though elegies promote knowledge about the life and character of a particular decedent, they also assure that bereavement is a common and survivable human experience. They range in tone from visions of bright and glorious afterlife for the deceased to gruesome description of a body during or after death.

This entry examines the origins and use of elegy over time. Notable poets who have produced elegies include John Milton, John Donne, Alfred Tennyson, Thomas Hardy, Ralph Waldo Emerson, Walt Whitman, Dylan Thomas, and W. H. Auden. The tradition of elegy is self-referential in that elements developed by ancient-era elegists have been invoked by their successors.

Origins of Elegy

In ancient Greek civilization, several centuries B.C.E., one rhythm or meter of poetry was the elegiac distich. It was a constraint of format rather than topic, as elegies tended to focus on intense subjects, such as politics, love, and loss. Poets, including Callinus, Tyrtaeus, and Archilochus, wrote song-like elegies to be accompanied by

musical instruments. Antimachus's "Lyde" was a collection of elegies written to assist the poet's recovery from the loss of his wife. Theocritus's idylls, featuring nature, deceased and grieving shepherds, and the shepherds' protective nymphs, were harbingers of the later English tradition of pastoral elegy. Roman/Latin elegists, including Ennius, Gallus, Propertius, and Ovid, devoted their efforts to love and eroticism.

During a pre-Islamic period starting in the 6th century C.E., an Arabic elegiac tradition arose; tearful weeping at graveside, participation in grief by the entire universe, and the incontrovertible role in death of Dahr, a fateful destiny, were all prominent. Females were believed to be especially emotional and advantaged as elegists. One praised example was al-Khansa, a contemporary of the Islamic prophet Mohammed, who wrote about her brother Sakhr's passing for the rest of her life. In the Muslim Spain of the 10th century, Hebrew poets such as Solomon ibn Gabriol and Moses ibn Ezra were encouraged to contribute to cultural tradition and did so in elegies that heavily echoed Arabic motifs.

European Elegy

The Middle Ages offered many elegies for royals that included contact with the dead and prophetic dreams. For instance, Geoffrey Chaucer's "The Book of the Duchess" probably honored the wife of John of Gaunt and portrayed a poet's dream of a hunt interrupted by a darkly clad grieving knight.

Only two 16th-century French poets received any acclaim for their elegies, the majority of which were not about death or grieving. Clement Marot's "Suite de l'Adolescence Clementine" included both love epistles and the "Complaintes," which lamented the passing of contemporaries. Marot may be best known for invoking tragic catastrophe, such as the burning of one elegy subject's bed and the drowning of another by river gods envious of his talent. Charles Fontaine also wrote many love elegies but later integrated a few examples of mourning in "Les Ruisseax de Fontaine." German poets of this era also produced elegy that rarely addressed death and loss.

Many great English poets of the 16th through 19th centuries contributed to the elegy canon. Whereas Thomas Churchyard ruminated on the dreary aspects of burial and bodily decay after death, Nicholas Grimald, Barnabe Googe, and Ben Jonson detailed characteristics of, and personal connections with, the deceased. Jonson also eschewed what he considered to be disingenuous displays of emotion. Edmund Spenser's "Astrophel" emphasized passage into an eternal state and the union of romantic partners in an afterlife while John Donne's "A Funeral Elegy" section of his "An Anatomy of the World: The First Anniversary" also exhibited great concern for the soul of the deceased.

Spenser's "The Shepheardes Calender" was a return to the pastoral sensibility of the ancient Greeks. The unifying components of pastoral elegy include simple address, dead contemporaries represented as shepherds and mourned as friends, mythological entities such as nymphs and muses, and bucolic locales that correspond to the natural acceptance of spiritual resurrection and afterlife. Milton's "Lycidas" mourned his fellow poet and minister in training, Edward King, as a shepherd lost to his flock of sheep. A majestic bitter emotion sweeps through his otherwise serene world as does a "blind Fury with th' abhorred shears." In Thomas Gray's pastoral "Elegy Written in a Country Churchyard," the narrator passes a graveyard, reflects on the likely humble status of its inhabitants, and resolves that emphasis on grandeur and glory in life is misplaced. Natural phenomena, such as moping owls, droning beetles, and morning breezes, abound in its 32 stanzas. Percy Bysse Shelley's "Adonais" portrays the English Romantic poet, John Keats, as the Greek vegetation god, Adonis, and is set among dewy flowers, fresh leaves, and moss.

The close of the 19th century found English poets considering the role of destiny in death. Tennyson, poet laureate of the United Kingdom, cajoled into creating a poem of thanksgiving for his own recovery from serious illness while at sea, instead produced an elegy for himself. In "Crossing the Bar," the barrier separating one from the sea of death is navigated by the pilot, who determines all outcomes. Hardy, writing often on the loss of his wife but also about suicides, wartime, and accidental deaths, seemed conflicted on whether a god or some unknowable force was responsible for evil and loss. Hardy's removed detachment marks his elegiac efforts such as "Drummer Hodge," in

which the deceased resides only in a small mound rather than among the constellations of stars above. Wilfred Owen, an eventual battle casualty himself, railed against the inevitable elimination of a generation of young European men in World War I. His war elegies, "Anthem for Doomed Youth" and "Dulce et Decorum Est," questioned the feasibility of adequate consolation for gassed, bootless soldiers whose "blood come gargling from the froth-corrupted lungs."

American Elegy

The course for elegy in the New World was initially set by the Puritan sensibility. An early New England tradition was to attach elegies to coffins; thus, only a fraction survived to become a type of family heirloom. As in Europe, the Puritan elegy was, to some extent, a self-reference. For instance, Cotton Mather's elegy for Urian Oakes, a top administrator at Harvard University, named other local elites who had created, or had been subjects of, elegy. By the 1730s, as Puritan practices of dour lamentation and longing for heaven faded somewhat from social life, Puritan elegy was ostracized. Nonetheless, the elegy satire tradition, practiced by noteworthy writers such as Benjamin Franklin and Mark Twain, has never extinguished the American passion to elegize.

One prominent and prolific producer of elegy in colonial America was Annis Boudinot Stockton, who wrote dozens of elegies in the latter half of the 18th century, including several for her husband, female friends, and celebrities such as Benjamin Franklin. Often adopting the pastoral elements, Stockton also utilized dialogue and explored issues such as the burdens of grief on friendship. Early 19th-century American elegists reinforced the honoring of the dead, history, and tradition. For instance, William Cullen Bryant's famed "Thanatopsis" revisited the English practice of graveside meditation while reminding readers that the dead actually exist to both haunt and guide the living.

Antebellum America fervently produced elegies to remember the children who did not live long enough to make history. Lydia Huntley Sigourney was such a renowned specialist in the child elegy that she was barraged with requests for customized exemplars. Alternatively, Transcendentalist writer Emerson was besieged by the deaths of his own wife and two brothers shortly before that of his 5-year-old, Waldo. In his elegies "Nature" and "Experience," he numbly ponders his losses and a grief that he somehow detaches from without scars.

Concurrently, African Americans expressed their enslaved status, culture, and resistance in song and literature; the elegiac form was no exception. Though Phyllis Wheatley's acclaimed elegies of the previous century were for whites, such as the English preacher George Whitefield, George Moses Horton was a Southern slave poet who published just as many elegies in the mid-1800s. Elegies for slaves were also key pieces of propaganda by abolitionists, such as Sarah Louisa Forten, as well as honest expressions of mourning for the dead and their difficult lives.

A great elegy was crafted by a renowned American poet upon the assassination of President Abraham Lincoln. Though Whitman's "When Lilacs Last in the Dooryard Bloom'd" is pastoral in tone and even portrays Lincoln as the shepherd to the nation, it also portends a shift toward symbolic and political remembrance of public figures. Nature emerges only in the end as apart from the grief and death of wartime. With his description of nameless wasted soldiers as debris of the Civil War, Whitman ushered in the modern elegiac response to calamitous and abundant fatality by way of war, genocide, and terrorism.

Born on the edge of the 20th century, a generation of poets began to shift from modes of comforting solace to accounts of incontrovertible loss, inconsolability, and unfulfilled quests for understanding. Thomas's "Do Not Go Gentle Into That Good Night" famously exhorts his dying father to "rage, rage against the dying of the light." Langston Hughes was an African American poet whose incorporation of musical blues themes into his poetry produced a mourning of social injustice and racial inequity rather than elegies for individuals. Auden, a noted writer of sonnets and love poems, strongly identified with the subjects of his elegies, even echoing their own characteristics in his form. He challenged Yeats, mocked the "unknown citizen" consumer of modern life, and even analyzed Sigmund Freud posthumously.

Passage into personal and psychological realms has marked elegy of the past half century. Beat

poet Allen Ginsberg mixed homosexual and scatological imagery with references to his mother's repulsive physical appearance and to the Kaddish in his elegy for her. Poet and novelist Sylvia Plath multiply elegized her menacing father, who also figured prominently in the journals that were released after her suicide. In elegizing both celebrities and the lesser known, New York school poet Frank O'Hara countered grief with vivid accounts of random contextual details. Adrienne Rich, a noted voice in poetry for the lesbian and feminist movements, purposefully avoided the suicide of her husband in elegies, choosing instead to honor the work and lives of women who might otherwise have been forgotten.

In light of these varieties of elegy, one thing appears certain. As it always has, elegy in the 21st century is likely to adopt new shapes while preserving, adapting, and discarding the various characteristics of its predecessors.

Michael Robert Dennis

See also Condolences; Eulogy; Funerals; Language of Death

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Embalming

Embalming is the use of a chemical process to provide short- or long-term preservation of a dead body. Modern embalming removes blood and gas from a body and typically the contents of its internal organs, and then treats the body with chemicals. The process and the preservatives used have changed considerably since its first practice by the ancient Egyptians. The reasons behind the process have varied from the religious and scientific to the hygienic and the psychological. Today, embalming is used mainly in North America (and to a limited extent in Great Britain and Australia) to provide short-term preservation of a corpse for viewing, typically within a week of death. Embalming continues to be used throughout the world to preserve cadavers for medical research. Though embalming is the norm and even considered traditional by the North American general public, the practice is not without its critics.

History

The history of embalming can be divided into three periods: the ancient Egyptian era, the period from the Middle Ages to the U.S. Civil War, and the current era, which began during the U.S. Civil War and continues to the present. Each period reflects different purposes and techniques. Some call the process before the use of arterial injection into the circulation system, embalmment. Embalmment involved evisceration, the removal of internal organs, packing the cavity with chemicals, and allowing the body to dry out. The development of arterial injection in the late 17th century marked a significant change in the process.

The ancient Egyptians started embalming during the First Dynasty (3200 B.C.E.) and continued the practice for 4,000 years. The purpose was religious: to preserve the body for reincarnation. The process usually included evisceration. The internal organs were preserved separately. The body was chemically treated in a lengthy process including a sodium salt bath. Treatment of the deceased had variations based on social rank and dynasty.

Embalming during the Middle Ages through the U.S. Civil War was mainly to preserve the bodies of important individuals or to preserve cadavers

for medical research. During this period, embalming shifted from the embalmment process using evisceration to arterial embalming, thanks to advancements in medical knowledge. Arterial embalming used a vast array of chemicals, such as oil of turpentine and camphorated spirits of wine in the late 1600s and then bichloride of mercury, zinc chloride, heavy metal salts, and arsenic compounds by the mid-1800s. The injection of chemicals would eventually make evisceration a rarer occurrence for the preservation of cadavers. As arterial injection embalming became more widely used in the 1700s, barber-surgeons were its main practitioners as they preserved cadavers for medical and scientific study.

Embalming bodies for the purpose of short-term preservation before burial received its first public notice during the U.S. Civil War and the embalming of President Lincoln and his son Willy before him. Embalming surgeons, such as Thomas Holmes and Richard Burr, embalmed thousands of soldiers during the war using gravity fluid injectors to inject their solutions. At this time, undertakers did not embalm but provided coffins and other services. After the war, embalming was not performed to a great extent in the United States until a number of inventions became widespread, undertakers became organized in associations, and embalming training spread.

In the late 1800s, if bodies were to be preserved, they were typically put on ice and/or wiped down by undertakers with disinfectants and preservatives. Important inventions helped change American funeral customs, including the discovery of formaldehyde as a preservative in the late 1880s. A 4% formaldehyde solution was developed in the 1890s and would hold up as the favorite solution for over a century, replacing the more toxic chemicals containing mercury and arsenic. The trocar for cavity aspiration was patented in 1878. When perfected, the trocar would make evisceration unnecessary. In the late 1800s cavity and arterial embalmers competed over which practice produced superior results. Eventually undertakers typically did both processes.

For embalming to spread, training and organization of the funeral industry was needed. The National Funeral Directors Association was established in 1882. Shortly before that, two funeral industry publications, *The Casket* (1876) and *The Sunnyside* (1871), were established. An embalming text, *The Undertaker's Manual,* was developed by Auguste Renouard in 1878. Finally many embalming schools were established in the 1880s. The first, in Cincinnati, was established in 1882. The modern funeral industry now had its footing as it worked to become an established profession.

The mass manufacturing of funeral products would occur in this same period. Dodge Chemical Company, the Champion Company, and Frigid Fluid Company, makers of embalming fluids, were founded in the decades after the Civil War. These companies were deeply involved in the development of the funeral industry. For example, the Dodge family founded and ran the Massachusetts College of Embalming, now part of Mount Ida College. Other funeral products, such as caskets, embalming tools, cooling boards, and hearses, would also be mass produced by 1900 to support the growth of the industry.

Embalming was done in the home of deceased as the funeral business started to apply the practice to the general public in the 1890s. Using the gravity fluid injector and a cooling board, the undertaker embalmed in the parlor or other room of the home. The body would be displayed in the parlor, for those who had one. The transition from home to funeral home for embalming and body display is not well documented. The typical explanation for this transition is that crowded tenements, smaller homes, and isolated families led to the need for the use of the funeral home.

Purpose

The purposes of embalming are contentious. Born out of the sanitation era of the 1880s, the funeral industry has typically said the main purpose of embalming is for disinfection and to protect public health. The funeral industry seems to be the only source still claiming embalming serves a public health function. Funeral industry critics such as Jessica Mitford and the Funeral Consumer Alliance claim the use of formaldehyde and other chemicals make the process more of a public health hazard than leaving the bodies to deteriorate naturally. In the United States, the Occupational Safety and Health Administration has set up numerous regulations regarding embalming and chemicals that are considered a danger to embalmers. Less toxic

alternatives to formaldehyde have been introduced into the field, including ethyl alcohol and polyethylene glycol, glutaraldehyde, and phenoxyethanol. But none of these seems to produce the favored effects of formaldehyde.

The other purpose of embalming, according to the funeral industry, is to slow decomposition to facilitate the creation of a "Beautiful Memory Picture," a concept coined by the funeral industry. Embalming provides the basis for the restoration of the body, to not only make it lifelike but to attempt to return the body back to the way the person looked before long- or short-term trauma took its toll. By introducing coloring, hydrating tissues, setting features, makeup, and possible reconstruction, the dead look asleep. This illusion is reinforced by an upholstered bed (casket) with a pillow and a mattress. This presentation has obviously become an expectation of the North American funeral ritual. Whether such a presentation of a body is needed to help facilitate the grief process is highly debated by critics of the practice. Many claim it feeds the denial of death that is prevalent in North American society.

The Process

The modern embalming process typically uses four processes: arterial, cavity, hypodermic, and surface embalming, as well as the setting of the mouth, the use of eyecaps, and shaving.

Arterial Embalming

Arterial embalming involves injecting chemicals (including preservatives and tint) into the circulation system, usually via the right carotid artery. A small incision is made just deep enough to cut the skin, and an aneurysm hook is used to raise the artery and vein. The artery is cut into and a tube is inserted. Blood is displaced from the right jugular vein. A clear hose is attached to the drain tube, and the hose from the embalming machine is connected to the arterial tube. The embalming machine has two knobs, which regulate pressure (the force of the fluid) and rate of flow (speed of the fluid). These knobs are adjusted to create the best rate of injection for the body. The 3 to 4 gallons (1 gallon per 50 pounds of the body) of embalming solution is injected while the embalmer massages (and perhaps washes) the corpse to ensure a proper distribution of the embalming fluid. In cases of severe injury, autopsy, or poor circulation, other injection points may need to be used. The jugular drain tube is opened periodically to allow blood to escape and prevent too much pressure from building in the vascular system. The blood drains directly into the sewer system.

A tint is also introduced into the body to simulate the presence of blood in the system. There are other fluids to break up clots, to restore dehydrated tissues, or to reduce fluid in tissues. The embalmer can choose from many concentrations of formaldehyde, depending on the condition of the body and amount of firmness the embalmer desires. The embalmer is able to gauge whether the body is fully embalmed by whether the tint has spread throughout the body, by the firmness of tissues from the solution, or by the flow of embalming solution from the jugular tube. The body needs to be positioned with embalming, because the solution stiffens the body into a permanent rigor mortis. Tubes are removed, veins and arteries are tied off, and the suture is sealed. The other steps in the embalming process tend to be less known to the public, especially the use of the trocar.

Cavity Embalming

In cavity embalming, the trocar punctures the skin just above the navel and is then pushed into the chest and stomach cavities to puncture the internal organs and aspirate their contents. A trocar is a long metal tube with a sharp point at one end with little holes to suck in material and gases. It is connected to a hose that is attached to a device that creates suction. The cavity is filled with preservative chemicals similar to the embalming solution. The hole made by the trocar is either sutured closed, or a trocar button is screwed into place.

Hypodermic and Surface Embalming

In hypodermic embalming, chemicals are injected under the skin as needed in areas the arterial embalming did not reach. Surface embalming is used to supplement the other methods, especially for visible, injured body parts. This is when an embalmer may "fill the features," building up

tissue to remove wrinkles, filling in lips, and building up other visible dehydrated areas like earlobes, fingertips, and the cheeks.

Facial hair of men, women, and children is shaved as part of the embalming process to avoid conflict with the cosmetics. Eyecaps can be placed under the eyelids. The eyes sink with dehydration and the burrs on the caps keep the eyes closed (or a form of Super Glue can be used to keep eyes closed). The jaws and lips also have to undergo distinct procedures. The jaw is typically permanently closed by passing a wire through the upper and lower gums and twisting the wires together. The position of the mouth, cheeks, and lips seem to be of particular concern to the embalmer. A mouth-forming device of metal or plastic can be placed behind the lips and lips and sealed with glue or straight pins. Various techniques are used to bring a "healthy" appearance to the mouth area and just the right expression.

Patrick Ashwood

See also Funeral Director; Funeral Industry; Mortuary Rites; Mortuary Science Education

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End-of-Life Decision Making

Several landmark court cases—The Karen Ann Quinlan case in 1975, the Nancy Cruzan case in 1990, and the Terri Schiavo case in 2005—have brought national attention to the significance and importance of having mechanisms in place for implementing care decisions at the end of life. Due to injuries sustained in an accident or unanticipated health events, these women were unable to make their own health care decisions. Because the women did not have written documents that clearly stated their wishes for sustaining life and their close family members disagreed about the type of care they should receive, decisions made about their end-of-life care resulted from lengthy legal battles. To avoid these undesirable situations and assist persons who wish to remain in control of health care decisions after they are unable to articulate their desires, states have enacted laws that allow for the creation of advance directives to help facilitate end-of-life decision making.

Advance directives are legal documents prepared by a competent individual that convey wishes regarding personal health care decisions. Two types of advance directives are the living will and durable power of attorney for health care. A living will enables individuals to express their wishes regarding life-sustaining treatment, such as the use of a feeding tube or ventilator for pulmonary failure. Narrow in scope, a living will authorizes the use or withdrawal of certain life-sustaining procedures only in situations in which individuals are mentally incapacitated and death from a terminal condition is imminent or if they are in a persistent vegetative state. Conversely, durable powers of attorney for health care are not restricted to terminal illnesses or prospectively identified situations. Instead, they give a broader range of authority to a trusted individual (i.e., surrogate) to make health care decisions only when the individual cannot make the decisions. Although any adult can initiate advance directives, the Patient Self-Determination Act, passed by U.S. Congress in 1990, requires that all federally funded hospitals and nursing homes give patients an opportunity to complete a living will and durable power of attorney for health care upon admission.

The driving force behind advance directive laws is the ethical principle of autonomy, which requires respect for persons' deliberate choices made in accordance with their own values, consciences, and religious convictions. By appointing a surrogate decision maker, the individual attempts to extend the principle of autonomy into situations of personal incompetence. The surrogate decision

maker is usually a family member who has sufficient knowledge of the person's values and desires to make the appropriate decisions. Executing advanced directives requires surrogate decision makers to adhere to the ethical principle of substituted judgment, wherein they are to replicate the same decision the person would have made had she or he been capable of making a decision. This standard requires that surrogate decision makers synthesize the person's diverse values, beliefs, practices, and prior statements to reconstruct what she or he would want under the specific circumstances. Surrogates have an implicit duty to follow the individual's presumed instructions by attempting to carry out those reported desires.

When the desires of the individual are not clear or the individual's preferences place him or her at undue risk, surrogates may use a current or best interests approach to assess whether treatment will advance the current and future welfare of the person. Surrogates determine whether the person's life is so diminished that he or she should have no further treatment, rather than if the person would choose continued treatment. Choices made using this approach may or may not be the same as the person's preferred decision, if known. Typically in these situations, physicians' judgments and recommendations regarding what is in the person's best medical interests are strongly considered. The differences between what is in the person's best medical interest and what is most beneficial to the individual, that is, in the person's best interest, often become blurred, with the best medical interest, "do no harm," winning out. Therefore, the best interest standard generally leans toward preserving life.

Less than one fourth of all American adults have advance directives documents in place. Most people tend to believe family members will know what to do if they face making such decisions. Older adults often want their families and physicians to make decisions on their behalf conjointly because they believed physicians' substantive knowledge combined with family members' concern for their well-being produces more accurate and effective decisions. However, without specific communications, persons cannot assume that their family members or physicians have sufficient knowledge of their preferences for end-of-life care. Even when individuals discuss their end-of-life care with family members or other surrogates, they often do not address specific life support preferences or treatments. Researchers frequently report poor agreement between what individuals say about the care they would choose for themselves in critical care situations and what their family or other surrogate decision makers would choose for them.

Health care providers often promote the use of a values inventory to encourage family discussions about end-of-life care. Completing such instruments provides an opportunity to share information with surrogate decision makers that will help them understand the person better. Such discussions are vital to guiding decision making, when future, unanticipated medical conditions prevail, and to ensuring the quality of care provided.

Karen A. Roberto

See also Life Support Systems and Life-Extending Technologies; Living Wills and Advance Directives

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Epidemics and Plagues

Epidemiology is the study of the distribution of diseases in populations and of factors influencing the occurrence of disease. Epidemiologists study both epidemic (excess) and endemic (always present) diseases. The basis of epidemiological science rests on the premise that disease does not occur by chance but rather that a range of environmental

and personal characteristics that vary within populations influence disease occurrence. Epidemiological studies, which include those seeking to explain the transmission of communicable diseases by determining commonalities among those who become ill, are an important basis for public health interventions and policies. In recent decades, epidemiologic studies have focused on a fuller understanding of factors influencing chronic conditions (e.g., diabetes, heart disease, and cancer) that are prevalent in developed countries. Studies of these factors have been successful in identifying personal characteristics and environmental exposures that increase the risk of disease, thereby contributing to preventative measures and public policy.

Epidemics

An epidemic may be defined as the temporary increase of cases of disease in a geographically defined area in excess of what is usually expected on the basis of recent experience. The general public associates epidemics with infectious diseases (also called "contagious" or "communicable" diseases) that are caused by pathogens (disease-causing organisms), which include bacteria, viruses, fungi, protozoa, parasites, and prions. The term *epidemic* derives from the Greek terms *epi* (upon) and *demos* (people). Because an epidemic depends on the "usually expected" number of cases of a disease within a population, even one case of a very rare or unexpected disease (e.g., smallpox) may represent an epidemic whereas many cases of a disease (e.g., malaria) would be classified as endemic rather than epidemic.

Other terms often associated with epidemic include *outbreak, cluster*, and *pandemic*. A cluster is a grouping (or aggregation) of cases of a disease or other health-related events or conditions that are related by time and place. *Outbreak* is a term used to describe a large number of cases of disease in a short period of time among a localized group of people. Clusters of sufficient size and importance may be considered outbreaks. A pandemic is an epidemic that is widespread and affects a whole region, a continent, or the world (e.g., AIDS). Other terms often found in epidemiological reports are *prevalence*, *incidence*, and *rate*. Prevalence is the number of diseased individuals (cases) at any one time (point prevalence) or over a given period (period prevalence). Incidence refers to the number of new cases of a disease, injury, or other condition that occur within a defined population over a given period of time. Rate may be thought of as the number of cases in a fixed number of people, for example, cases per 100,000.

Epidemics are caused by a common source of infection, such as food or water. Common-source epidemics can cause illness in large numbers of persons. Examples of common-source epidemics include botulism (from soil-contaminated food), cholera (from fecal-contaminated food and water), typhoid fever (from fecal-contaminated food and water), and brucellosis (from milk or meat of animals infected with *Brucella* spp.). Host-to-host infections, on the other hand, are transmitted from one infected individual to another through direct contact or through a carrier. Examples of host-to-host epidemics include tuberculosis (from inhalation of airborne particles), measles (from human sources), and hantavirus pulmonary syndrome (from inhaled fecal material of carrier rodents). Host-to-host epidemics tend to grow and to abate more slowly than common-source epidemics, because the latter type of epidemic generally stops once the source of infection has been identified and removed.

Disease-causing organisms are transmitted through several main routes of entry: skin, respiratory tract, gastrointestinal tract, genitourinary tract, and conjunctiva (eyes). Coughing, sharing contaminated needles, and sexual intercourse are activities that hold the potential to spread pathogens from one person to another. Whether an individual who has been exposed to a pathogen develops an infection depends upon several host factors, including age, metabolic state, immune status, and genetic factors. An infected person, especially one infected with a virus, may not develop disease or may have only a mild case of disease; however, an infected person, without apparent disease, may transmit the infection to other persons.

In recent years, epidemics of infectious diseases have captured worldwide attention because of the potential in modern society for rapid spread of infectious diseases from one part of the world to another; the potential use of pathogenic microorganisms as weapons; fear and panic regarding the

lethality of certain organisms; and the means to communicate instantaneously information about emerging and infectious diseases. Epidemics, which appear to come and go unpredictably, can affect large numbers of people. Prior to the advent of effective treatments for many infectious diseases, epidemics frequently killed thousands, even millions, of people. Even today, diseases such as malaria and tuberculosis kill millions of people each year, mainly in resource-poor nations. Although vaccines have been developed to prevent many infectious diseases, these vaccines do not always reach the most vulnerable persons, resulting in the deaths of as many as 2 million people each year from vaccine-preventable diseases. Still other vaccines and drugs are in development to prevent and treat infectious diseases such as tuberculosis and malaria that are endemic in many parts of the world.

The current level of interest in infectious diseases might seem illogical in light of improvements in living standards, the introduction of vaccines and antibiotics, and a worldwide reduction in the number of deaths from infectious diseases. But recent epidemics of HIV/AIDS, West Nile virus, mad cow disease, multidrug-resistant tuberculosis, and swine flu, among many others, highlight the enormous public concern regarding epidemics resulting from infectious organisms. In addition, movies of the "deadly virus at large" genre have fueled public interest in epidemics. Examples of such doomsday movies include *The Seventh Seal* (1957), *Masque of the Red Death* (1964), *The Cassandra Crossing* (1976), *The Carrier* (1987), *The Black Death* (1992), *Outbreak* (1995), and *28 Days Later* (2002).

Modern epidemics are often associated with "emerging and reemerging" infectious diseases. The National Institute of Allergy and Infectious Diseases of the National Institutes of Health has classified emerging diseases as outbreaks of previously unknown diseases or known diseases whose incidence in humans has significantly increased in the past 2 decades (e.g., hepatitis C, Lyme disease, ehrlichiosis). Reemerging diseases are known diseases that have reappeared after a significant decline in incidence (e.g., mumps virus, *Staphylococcus aureus*). Epidemics of emerging and reemerging infectious disease can be attributed to several factors that were reported in the Institute of Medicine's 1992 report *Emerging Infections: Microbial Threats to Health in the United States*. These factors include a complacency regarding emerging infectious diseases; changes in human demographics and behavior; socioeconomic factors, especially poverty; advances in technology and industry; economic development and changes in land use; increased frequency and speed of global travel and commerce; adaptation of microbes; and deterioration in the public health system at all levels. Other factors often cited for epidemics include changes in the mass production of food products (and increased import of food products), climatologic changes and environmental degradation, war and natural disasters, and the deliberate release of microorganisms as an act of war or terror.

The World Health Organization has reported that in the past 3 decades, more than 30 new organisms have been identified worldwide, further underscoring the need for strong political commitment and financial support to ensure coordinated approaches to the prevention and control of infectious diseases around the globe. Reemerging diseases are also an ongoing challenge because human genetic factors allow new strains of known pathogens to appear to which the immune system has not been previously exposed. The National Institute of Allergy and Infectious Diseases further notes that many pathogens have developed resistance to antimicrobial drugs, allowing the resurgence of some formerly treatable diseases. Health care–associated infections, especially methicillin-resistant *Staphylococcus aureus*, serve as other examples of infections that have grown resistant to antimicrobial drug treatment. Failure of children and adults to obtain recommended vaccinations has also contributed to the reemergence of formerly controlled diseases. Finally, many infectious diseases (e.g., polio) have never been adequately controlled in some parts of the world. Some of these diseases, which were previously limited to certain parts of the world, now pose a threat to the U.S. population.

Plague

The term *plague* refers to an infectious disease of humans and animals caused by the bacterium *Yersinia pestis*. Plague is also an ancient term with a biblical heritage that has a broader meaning. In

the book of Exodus, God unleashed 10 plagues on Egypt in an effort to free the Israelite slaves. These plagues included a number of calamities: changing rivers to blood, causing disease in livestock, mixing hail and fire, and causing boils that would not heal. The disease plague, also called "the black plague" or "the black death," caused three recorded pandemics throughout history: the plague of Justinian (541–542 C.E.) killed an estimated 100 million people worldwide; the black death (1347–1351 C.E.) killed an estimated 100 million people in Asia, Europe, and Africa; and the third pandemic (mid- to late 19th century) killed millions of people worldwide. While there are several theories regarding the origin of plague, many historians believe the disease may have originated in China.

Plague is transmitted to human beings from the bite of a rodent flea that carries the plague bacterium or by the victim handling an infected animal. After an infected rat dies, the flea seeks another warm-blooded host, including human beings. Plague may be manifested in three forms: (1) bubonic (lymphatic system) plague (85% of cases), (2) septicemic (bloodstream) plague, and (3) pneumonic (lung) plague. With the most common form of plague (bubonic), the plague bacillus travels from the site of the flea bite to the nearest lymph node (neck, groin, or armpit), where it reproduces and causes the lymph node to swell. Septicemic plague can be caused both from flea bites and from contact with infective materials through breaks in the skin. Pneumonic plague, which results from inhalation of aerosolized droplets of infective bacteria, is the least common but most virulent form of plague. Only pneumonic plague has a high risk of person-to-person transmission.

Effective treatment for plague includes early diagnosis, the early administration of antimicrobial agents, and provision of comfort and supportive measures. *Untreated* plague has a high mortality rate (50% or higher), which drops to 15% with early diagnosis and treatment. In ancient times, persons with plague were subjected to quarantine. It was not until the germ theory of Louis Pasteur was accepted and built upon by such scientists as Joseph Lister and Robert Koch that scientifically based treatment approaches to infections became standard.

In modern times plague remains a threat to human health. Wild rodents in certain areas around the world (e.g., Madagascar, Tanzania, Brazil, Peru, Burma, China, and Vietnam) are infected with plague. In the United States these hosts are mainly ground squirrels, prairie dogs, wood rats, deer mice, chipmunks, and moles. Recent studies indicate a small percentage of human disease is caused by the scratches or bites of infected cats. Most cases of plague in the United States occur in the western third of the country, primarily in northern New Mexico, northern Arizona, southern Colorado, southern Oregon, western Nevada, and California. While only about 10 to 15 isolated cases of plague are reported in the United States each year, the World Health Organization reports 1,000 to 3,000 cases of plague annually. According to the Centers for Disease Control and Prevention, the last urban plague epidemic occurred in Los Angeles in 1924–1925.

A plague vaccine was discontinued by its manufacturers in 1999 and is no longer available. Plans for future licensure and production are unclear. This could become a problem in the future, for even though plague is relatively rare today, bioterrorism experts have raised concerns about the possible use of *Yersinia pestis* in an aerosol attack, which could possibly spread the pneumonic plague. Although creation of such a bioweapon is theoretically possible, bioterrorism experts report that such a weapon would require advanced knowledge and technology. A working group of biodefense experts has determined that *Yersinia pestis* is one of the most serious of "critical biological agents" that could be deployed by terrorists. Their concerns stemmed from the availability of *Yersinia pestis* around the world, the potential capacity for its mass production and aerosol dissemination, difficulty in preventing such activities, the high fatality rate of pneumonic plague, and the potential for secondary spread of cases during an epidemic.

Epidemics Through History: A Brief Overview

Throughout recorded history, epidemics have shaped civilizations. Listed here are some of the more notable epidemics that have affected large numbers of people and about which much has been written by social historians. This listing represents only a fraction of the many regional and

global epidemics throughout recorded history: leprosy in medieval Europe; cholera epidemics in the 19th century; the great plague of London (1665); the Boston smallpox epidemic (1721); influenza pandemic (1781–1782); the yellow fever epidemic in Philadelphia (1793); tuberculosis in Europe and North America (1800–1922); the first cholera pandemics (1817–1824); typhoid fevers in cities (1850–1920); yellow fever in New Orleans (1853); smallpox in Europe (1870–1875); Spanish influenza in North America (1918–1919); syphilis (1494–1923); poliomyelitis in the United States (1916–1950s); tropical diseases during the construction of the Panama Canal (1904–1914); AIDS pandemic (1980s–present); severe acute respiratory syndrome (SARS) outbreak (2003).

In recent times, infectious disease epidemics have created sensational headlines around the globe. Many of these epidemics are caused by emerging and reemerging infectious diseases. A review of topics treated in the online journal *Emerging Infectious Diseases* provides an overview of some of the diseases of greatest concern: avian and swine influenza; West Nile fever/virus; drug-resistant tuberculosis; legionellosis; dengue fever; Ebola, Marburg, and Lassa fevers; Rift Valley fever; tick-borne encephalitis; S ARS; Creutzfeldt-Jakob disease; hantavirus pulmonary syndrome; cryptosporidiosis; HIV/AIDS; drug-resistant pneumococcal pneumonia; *Escherichia coli* 0157:H7 infection; anthrax; *Cyclospora cayetanensis*; measles; and hepatitis. Some of these diseases have caused outbreaks of highly lethal diseases in a relatively small number of countries (e.g., avian influenza), whereas others (e.g., West Nile virus) have been more widely dispersed, although not as lethal. Some of these diseases have "emerged" or "reemerged" because their hosts' immune systems are suppressed or simply because of improvements in recognizing or testing for the diseases.

Tracking and Controlling Epidemics

All nations have systems in place to identify outbreaks of infectious diseases, to conduct investigations, and to institute control measures. Some nations, particularly resource-rich nations, have rapid response systems to investigate outbreaks and quickly implement control measures. In addition, ongoing surveillance of infectious diseases, including the use of early warning systems, are important features of many nations' public health systems. In the United States, the federal Centers for Disease Control and Prevention (CDC), headquartered in Atlanta, Georgia, has a broad mission that includes a mandate to investigate, initiate, and maintain activities to control infectious diseases. The CDC consists of various divisions, including the National Center for Infectious Diseases. The Council of State and Territorial Epidemiologists (CSTE) is a professional association of over 1,050 public health epidemiologists working in states, local health agencies, and territories. The CSTE provides technical advice and assistance to public health agencies such as the CDC. CSTE members have surveillance and epidemiology expertise in a broad range of areas, including infectious diseases.

In 2000, the World Health Organization initiated the Global Outbreak Alert and Response Network (GOARN), which is a technical collaboration of existing institutions and networks that pool human and technical resources for the rapid identification, confirmation, and response to outbreaks of international importance. The GOARN provides an operational framework to link this expertise and skill to keep the international community constantly alert to the threat of outbreaks and ready to respond. Health Canada's Global Public Health Intelligence Network (GPHIN) provides an Internet-based "early warning" system that gathers preliminary reports of public health significance 24 hours a day. The GPHIN multilingual system gathers and disseminates relevant information on disease outbreaks and other public health events by monitoring global media sources such as news wires and websites. Notifications about public health events that may have serious public health consequences are immediately forwarded to users.

While regional collaborations among nations (e.g., South Asian Association for Regional Cooperation) were initially developed to promote economic development, member nations now collaborate around public health issues, including disease outbreak containment. The World Health Organization has identified regional networks of laboratories, scientists, and clinicians that can be mobilized when an outbreak of a serious disease threatens public health. This level of international cooperation is critical to contain disease outbreaks, especially when these outbreaks occur in countries

or regions that do not have the needed infrastructure and resources.

Jerry Durham

See also Acute and Chronic Diseases; HIV/AIDS; Megadeath and Nuclear Annihilation; Terrorism, Domestic; Terrorism, International

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Epitaphs

An epitaph is a short phrase that honors a deceased person, usually inscribed on a tombstone. The English word *epitaph* is derived from the Greek *epitaphios*, which translates literally as on or at (*epi*) the grave (*taphos*). In its verbal form, the word refers to the performance of rituals at a grave and the meaning developed to refer to the text inscribed on a grave marker. Epitaphs that indicate the name of the deceased have their origin in ancient Greece and Rome, but epitaphs that express aphorisms also have an ancient and modern literary tradition.

In ancient Greece, an upright stone slab (*stele*) marked the location of a burial and an inscription on it communicated the identification of the deceased. These two rituals of commemoration were not always combined: With the development of writing, the custom of identifying the deceased originated in Egypt and among the Minoan-Mycenaean civilizations, even though the location of a burial had also been communicated earlier, whether through a tumulus mound, a monument, or a pile of stones, in other regions of Europe, Africa, and Asia. Greek steles and columnar markers (*kioniskoi* or *columellae*) could be simple, containing only the name of the deceased, or could be more elaborate, like those in Attica, that were often decorated with sculpture and contained epitaphs that could, in addition to recording the name of the deceased, include aphorisms addressed to passersby on the brevity of life and the inevitability of death. Perhaps the most famous Greek epitaph is the one composed by Simonides of Cos that records the burial location of the fallen Spartans at the Battle of Thermopylae in 480 B.C.E.: "Stranger, tell the Spartans that we who lie here obeyed their orders."

The epitaph is emulated on the Kohima epitaph (attr. John Maxwell Edmonds) that frequently appears on veteran memorials: "When you go home, tell them of us and say, / for their tomorrow, we gave our today." Other epitaphs associated with famous battles and military service include variations on this sentiment, such as the epitaph that commemorates the British dead at the Battle of Concord, Massachusetts (April 19, 1775): "They came three thousand miles and died / To keep the past upon its throne; / Unheard, beyond the ocean tide / Their English mother made her moan" and the Vietnam Veterans Memorial in Washington, D.C., designed by Maya Ying Lin, which records the names of fallen soldiers in chronological order of date of death. The absence of names on the Tomb of the Unknown Soldier at Arlington National Cemetery adds to the pathos of a monument that celebrates the military service of those denied an individual burial or commemoration.

Latin epitaphs were inscribed on funerary monuments, simple markers (*cippi*), or even painted on small marble plaques (*tituli*). The first known epitaph in Latin is that of L. Cornelius Scipio Barbatus, consul in 298 B.C.E., which was inscribed on his sarcophagus and is now displayed in the

Vatican Museums. Verse epitaphs developed concurrently with elegiac poetry in the late 2nd century B.C.E., and both share the elegiac meter (elegiac couplet of alternating hexameter and pentameter verse). The earliest verse epitaph commemorates Cn. Cornelius Scipio Hispanus (consul in 135 B.C.E.), a descendant of Scipio Barbatus. Elegists such as Propertius, Tibullus, and Ovid, writing in the Augustan period, include epitaphs within the texts of their elegies. The tradition was revived by the Christian poet Ausonius in the 4th century C.E. in his verse epitaphs of mythological figures and his *Parentalia,* a collection of epitaph poems, named after the pagan festival honoring the dead, addressed to his dead relatives.

Not all Latin epitaphs, however, were written in verse. The majority contained information that occupied several lines. Epitaphs could be in the first or third person and, like Greek epitaphs, could include biographical information of the deceased and their survivors or aphorisms addressed to a passerby. Like the modern "rest in peace," a common sentiment expressed a hope for the comfort of the deceased: "may the earth lie lightly on you" (*sit tibi terra levis*). Many Roman *tituli* and funeral monuments, actual tombs, and sarcophagi survive in Rome and are incorporated into museums where they now share exhibition space with famous sculptures of antiquity. Fragments of funerary inscriptions are also displayed in church narthexes and the walls of courtyards and loggias.

Modern epitaphs are valued for their wit or unpretentiousness. Thomas Jefferson makes no mention of his presidency on his epitaph, but the epitaph of Sir Winston Churchill makes light of Judgment Day: "I am ready to meet my Maker. Whether my Maker is prepared for the great ordeal of meeting me is another matter." The epitaphs of famous authors and actors also attract attention. The tombstone of John Keats, who died in Rome, incorporates a lyre and a dictation of his final words: "This grave contains all that was mortal of a young English poet who on his deathbed and in the bitterness of his heart at the malicious power of his enemies desired these words to be engraven on his tombstone 'Here lies one whose name was writ in water.'" The American actress Bette Davis is remembered by the humorous observation: "She did it the hard way."

Contemporary funerary practices have altered the traditional appearance and roles of epitaphs: Newspaper or online obituary notices function as epitaphs even though the text does not appear where the deceased is buried. The growing popularity of green cemeteries, in which the dead are buried in biodegradable coffins with no tombstone in order to have as little an impact on the environment as possible, is also changing commemoration of the dead. Green cemeteries are the antithesis of ancient burials: Whereas funeral monuments in classical antiquity intended to immortalize the deceased, green cemeteries strive to make as little impact on nature as possible by the deceased, who surrenders permanence and textual immortality for environmental responsibility.

Mario Erasmo

See also Cemeteries; Cemeteries, Virtual; Monuments

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Equivocal Death

An equivocal death is one that cannot be neatly categorized as specifically natural, accidental, suicidal, or homicidal. Every death, independent of its cause, is classified by the coroner as one of these four modes. Equivocal deaths are those inquiries that are open to interpretation; they are uncertain and unclear. Occasionally, there is a death which, although clear as to its cause, is ambiguous and equivocal as to its mode, usually between accident and suicide. However, the mode of almost any death can be mistaken for another when the circumstances are not clear. The facts are purposefully vague or misleading as in the case of a staged crime scene. Death is suspicious or questionable based upon what is presented to the authorities; it may resemble homicide or suicide, accident or

natural. It is open to interpretation pending further information of the facts, the victimology, and the circumstances of the event. General guidelines issued by the U.S. National Association of Medical Examiners state that the undetermined manner-of-death classification is to be used "when the information pointing to one manner of death is no more compelling than one or more other competing manners of death in thorough consideration of all available information."

Drug-related deaths can be among the most equivocal as to the mode of death. Proper certification often necessitates knowledge of the victim over and beyond standard toxicological information, including such questions as what dosage was taken (related to the exact time of death) and the time at which autopsy blood and tissue samples were taken; the decedent's weight and build; the decedent's long-term drug habit and known tolerance; and the possible synergistics of other ingested materials.

Death by hanging is usually considered to be instances of suicide (excluding executions). Hanging, like shooting oneself, ingesting a quick-acting poison, or jumping from a high place, is one of those methods by which one reaches precipitously the conclusion of a case of suicide. However, some cases of hanging or asphyxiation are equivocal, such as in the case of deaths involving men who seemed to be engaged in autoerotic activity judged by such features as partial nudity, binding of the body and the genitals, pornographic writing and pictures, and special fetishes such as articles of female clothing, leather belts, and chains. Although the investigation of death orientation of these people may add relevant details regarding their lives (such as loneliness, isolation, hopelessness, and suicide attempts), they should accurately be counted as accidental rather than as suicide. Sometimes a delay of time between the self-destructive action and the death, or intervening events, clouds the direct sequence of cause and effect and creates difficulties in certification.

The certification of the death certificate is a very important item, of great import to the survivors, with implications for insurance, for reputation, even for criminal prosecution. According to classical suicidology, a sizable percentage of deaths (up to 15%) are equivocal regarding the mode, and most of these are eventually certified as accidental, without an adequate psychological investigation. Some of these uninvestigated equivocal deaths are in fact suicides. Pioneer studies conducted at the Los Angeles Suicide Prevention Center by Shneidman and associates recommended that in equivocal cases, the coroner use behavioral scientists to conduct a psychological autopsy, interviewing key survivors who can throw light on the decedent's motivations. It is widely acknowledged that the specialists on whom the coroner traditionally calls (e.g., the pathologist, the toxicologist, the biochemist) can fairly accurately tell the cause of death, but the social scientist is in a pivotal position in cases of equivocal deaths to render the most significant information as to the victim's intention to kill himself or herself. Intention and motivation are neither chemical nor tissue matters; they are psychological in nature. This is where the social scientist can assist the coroner's office.

A new era for understanding equivocal deaths may be identified in the collaboration between a group of psychiatrists or psychologists representing the Los Angeles Suicide Prevention Center and the Los Angeles County Chief Medical Examiner-Coroner (Theodore J. Curphey). In fact, the local medical examiner was interested in studying the cases of death in which a suicide was a possible but not the only possible interpretation. Curphey believed that the central role in an accurate certification of death lies with the coroner, together with the interests of the community's public health. Shneidman had proposed that the motivation is present in some deaths and that a comprehensive taxonomy of deaths must include components that reflect the role of the individual in his or her own death. For example, an intentional death is that in which the decedent played a direct and conscious role in affecting his or her demise, whereas an unintentional death is that in which the decedent did not affect his or her demise. The definition of a subintentional death was then introduced as a death in which the decedent played some partial, covert, or unconscious role in hastening his or her demise, that is, unconscious motivation that contributes to the person's fatal accident, failing health, or even being murdered.

The psychological autopsy is based on the incontrovertible commonsense principle that, in an equivocal death, additional relevant information is always useful. The psychological autopsy method

involves a retrospective investigation of the deceased person, within several months of death, and uses psychological information gathered from personal documents; police, medical, and coroner records; and interviews with family members, friends, coworkers, school associates, and health care providers to classify equivocal deaths or establish diagnoses that were likely present at the time of suicide. In cases of equivocal death, there are at the least three questions to which the psychological autopsy can help find answers: Why did the individual do it? (especially if suicide is the most probable option); How did the individual die? (when a death, usually a natural death, is protracted, the individual dying gradually over a period of time and sociopsychological reasons why he or she died at that time are taken into account); and What is the most probable mode of death? (establish the mode of death with the greatest degree of accuracy as possible). The psychological autopsy focuses on what is usually the missing element, namely, the intention of the deceased in relation to his or her own death.

Certification of equivocal deaths usually lacks any attempts to establish the intention of the decedents with regard to their own demise. Uncertainty about the correct certification is particularly accentuated when the victim's intention is ambivalent, with coexisting wishes both to live and die, or when the self-destructive action is in itself inconclusive, or when death follows the action after a considerable delay.

Maurizio Pompili

See also Coroner; Death Certificate; Psychological Autopsy; Suicide; Thanatology

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ESCHATOLOGY

Eschatology deals with questions about the final destination of human beings, including the question of an afterlife. When people face life's finitude, they feel a need for a perspective that extends beyond mortality. In the case of death, they look for a completion of human life that transcends death. More generally, the field of eschatology covers the doctrine (Greek: λόγος) of the end-time (έσχατος). The end-time is one of the primordial problems of human life. The search for ideas and beliefs concerning the end-time is associated with the universal question of whether all humankind and the world can expect a future that transcends the ephemeral, regardless of transience. Religious traditions have devised various responses to these issues. Connected with the question about the end-time, people ask questions about the time of genesis. The question about the destination of human life and the cosmos is linked to the question of their origin, the subject matter of what is known as protology. Where do humans come from before their birth and where do they go to after death? Since the latter half of the 19th century, scholars of religion have tried to collect the various answers to the question about the end-time and to discern broad patterns in these answers. This effort evolved into what is now known as eschatology, which relies on theology, anthropology, psychology, ethics, philosophy, and sociology.

Personal and Collective Eschatology

In the current social climate, eschatology is very much in the limelight. The confrontation with death raises questions when individualization and the secularization of society compel people to find their own answers. In addition, environmental

pollution and climatic change create new scenarios of the end-time. These are depicted in various ways in religions and new spiritual or esoteric trends, as well as in philosophy and public debate.

There is a distinction between personal eschatology and collective eschatology. Personal eschatology concerns what awaits each human individual after death. Collective eschatology deals with the end-time in general. At issue is what happens to humankind and the entire world when time comes to an end. There are many possible answers, of which some examples are described in this entry to illustrate the substance and function of eschatology in people's handling of mortality.

Personal Eschatology: What Happens to Individual Persons After Death?

Personal eschatology focuses on the individual's lot in an ultimate perspective. The question of how individual human beings came into existence or where they come from (protology) raises the issue of where they go or return to after death (eschatology). Eschatology concerns the possibility of continued existence after death. There are various conceptions of life after death, which are viewed from the angle of diverse sources and from different perspectives.

One can distinguish between several dimensions of personal eschatology. The first is an anthropological dimension. The second is a psychological dimension. The third is the religious dimension of personal eschatology. Finally, these three dimensions give rise to an ethical dimension of personal eschatology.

Anthropological Dimension of Personal Eschatology

Anthropologically, eschatology provides a substantive bridge between the world of the living and the world of the dead. This bridge is often portrayed ritually. According to the scholar of ritual Arnold van Gennep, death entails a twofold transition. The survivors make a transition from life with the deceased to life without that person. At the same time the deceased makes a transition from the world of the living to the world of the dead. In van Gennep's view, the transition always proceeds in three phases: One is separated from the world of the living (first phase), one finds oneself in a sort of intermediate state between life and death (second phase), and finally one is incorporated into the world of the dead (third phase). This classically structured rite of passage shows that there has to be a link connecting the worlds of the living and the dead. To the survivors, eschatology offers images of the world of the dead that can provide such a link. One possibility is that the deceased is initiated into a new life after death, enacted in, for instance, deathbed or funeral rites. Initiation into the world of the dead could mean the final step in a person's life. Already among the ancient Egyptians one finds the view that heaven is a person's final destination, from which there is no return.

Another conception is that the deceased makes a transition to ancestorhood. That makes the person an object of ancestor veneration and, as such, accessible to his or her relatives. This kind of eschatological image concerns the deceased and his or her destiny. It also concerns possible communication with the deceased that bridges the gap between life and death. Through ritual activity the surviving relatives can contact the dead. Through lamentation or, in some cultures, a "second funeral" some time after the person's death, people are able to remain in contact with the deceased, as described by Robert Hertz. In this way the deceased can act as a mediator between the here and now and the hereafter.

Psychological Dimension of Personal Eschatology

According to psychological theory, the question of people's destiny after death is deeply rooted in the human psyche. The psychologist Robert Lifton maintains that people have an inescapable need to ensure continuity in the face of death. This happens by way of what Lifton calls "symbolic immortality" in the form of images of life after death that facilitate the psychological mechanism for coping with bereavement. Thus it has a place in eschatology, as it affords a psychological slant on human beings' ultimate destiny. Lifton distinguishes between different modes of immortality, which reflect the need for symbolic images. The first is the biological mode, in which people live on in their descendants. Then there is the creative mode, which means that people are immortalized by their legacy, their work, and their relations with others. The third is the transcendental mode, which includes religious conceptions of life after death. The natural mode of immortality traces

human survival in nature. The cycle of nature continues even after the death of the individual person and everyone is included in it. Lifton's final mode is experiential transcendence, which entails transcending the limits of time, space, and, ultimately, death through an experience of self-transcendence. This experience enables people to find a destiny beyond death. The question of personal destiny that is the subject of eschatology is a psychological mechanism to deal with death, be it one's own or that of a loved one. Thus empirical research has shown that the biological mode of immortality actually helps people cope with death. Robert Kastenbaum found that 90% of people with children and grandchildren can handle death more easily than those with no progeny.

Religious Dimension of Personal Eschatology

Religious personal eschatology has two basic notions. According to the first notion, the individual—a person's body or ego—is the mortal shell of a permanent principle, which continues to exist even after the shell, the individual person, perishes. The second possibility is that the person as a whole—body and mind—lives on after death. In that case the actual individual, including his or her body, does not perish. This notion of a permanent principle is found, for example, in Eastern religions. When a person is reborn, he or she is no longer the same incarnation as before his or her death. The individual has died and no longer exists; the permanent principle remains.

The second possibility—survival of the entire person, often including the body—is found in prophetic religions. In Christianity the resurrection means that the entire human being lives on in heaven after death. This second kind of religious conception of life after death often centers on religious events entailing a particular hope of salvation. An example is the death and resurrection of Jesus Christ. Because of this event, Christians believe that they will follow Christ after their death. As in the case of Christ's resurrection, a salvific event may be followed by disappointment. After Christ had risen and ascended to heaven, his disciples expected his speedy return to earth and the dawn of the end-time (*parousia*). When that did not happen, the idea took shape in personal eschatology that after their death, all people would rise with Christ. In early Judaism the resurrection of the dead played a minor role. Only in Greco-Roman thought does one find a stronger belief in the resurrection. Nonetheless one finds a reference to the resurrection in the Hebrew Bible's book of Daniel 12:2: "Many of those who sleep in the dust will awake." On the day of the last judgment three groups of people will rise again: the righteous, the wicked, and those in between. The righteous are given eternal life, the wicked go to hell, and the fate of those in between is negotiable. We observe that God's judgment will play a prominent role and that the notion of the hereafter is divided into different parts: heaven, hell, and sometimes an intermediate state, known in Catholicism as purgatory. In Islam, too, the idea of paradise that will not be attained by everyone plays a major role. All of these images represent a belief in life after death that makes the world of the dead religiously conceivable to the living—in Islam, for example, in the form of a luxuriant garden.

Ethical Dimension of Personal Eschatology

The eschatological notion that humans are judged after their death involves an ethical component. In what are known as redemptive religions, death is followed by reward for a virtuous life or punishment for an evil life. In the Abrahamic religions humans' fate after death depends on the way they lived their lives. It is a major motivation for ethical living. The idea of purification after death implies that after their death, people can do penance for sins committed in their lifetime. In Catholicism this happens in purgatory. After a spell of purification, they can still enter paradise. Religions that assume the survival of the eternal core of the person rather than the survival of the entire person also have this ethical component. In the Buddhist view the karma that people accumulate in their lifetime by doing good deeds determines in what way they will be reincarnated. This ethical component means that there is a close connection between a person's earthly life and the life after death expressed in personal eschatological ideas.

Collective Eschatology: What Happens to Groups at the End of Time?

Apart from individual conceptions of what happens to people after death, there are many notions

of the end-time for humankind as a whole or even the entire world. End-time scenarios in collective eschatology are almost invariably linked with religious images: A transcendent power influences the fate of humankind and the world. Usually this happens in the history of a particular group. Hence collective eschatology has three major aspects: a historical aspect, a transcendent aspect, and a social aspect.

Historical Aspect of Collective Eschatology

Especially in the Abrahamic religions, eschatology is historically inspired. In Judaism, for instance, this means that God intervenes decisively in history, because God is superior to the world and its events. At a given time all of this will culminate in God's ultimate appearance in history—a time when mundane limitations will no longer apply. In Judaism God's appearance in history means the coming of the Messiah and a political and social revolution. The end-time or *Eschaton* means that God will wage war on evil people—the enemy—and injustice. The Babylonian Talmud points out that the future world will not be the same as the here and now: There will be no eating and drinking, no procreation, and no rivalry between people. The righteous will be exalted with crowns on their heads and will bask in God's presence. There will be no more death, no cares, and no tears. All that remains will be observance of divine law, a crucial element of Judaism, which will then be taught by God. Often these salvific hopes stem from people's real-life historical circumstances, the earthly injustices that the people of Israel experienced time and again.

Despite all dangers, Judaism interprets all history as God's way with his people of Israel—what is known as salvation history. That means that God sees to it that his people continue their journey through the ages and will ultimately inherit a good future. A key symbol of that future is the promised land. This is linked with the notion that God will keep his promise to Israel: The people will be restored in the promised land of Israel, and the sacrificial cult will be practiced once more in a rebuilt temple. Historical eschatological ideas help people to live with the wretchedness of daily life. Collective eschatology seeks to keep an ultimate perspective alive for a group of people, a perspective that includes the individuals and their personal finitude.

Transcendent Aspect of Collective Eschatology

As in personal eschatology, where a link is established between the world of the living and the world of the dead, collective eschatology links earthly life, human life, and the divine. Divine reality represents transcendence. In eschatological images, God, the transcendent par excellence, arrives in immanent reality. As a result, the disparity between the divine and the human world will eventually be overcome. In Judaism, however, one finds that despite the bridge between the transcendent and the immanent, there is some hesitancy when it comes to concrete images of that link. These would make it too tempting and will distract people from the here and now by overaccentuating the end-time.

In Christianity the coming of the Messiah heralds a new step in salvation history: God who has finally revealed his salvation. The person of Jesus Christ represents the embodied link between the transcendent and the immanent. Jesus is both divine and human. That means that in Jesus, God himself became immanent and thus made transcendence accessible once and for all. It should be remembered, however, that Christian doctrine also includes the Messiah's return to earth and the end of time. On that day all people will be judged, the living and the dead. At the last judgment transcendence will be victorious, a notion also encountered in Islam in the form of angels that will report the good and evil deeds of every person to God. The individual's fate after death is, in that sense, included in collective eschatology.

Social Aspect of Collective Eschatology

The social aspect of collective eschatology, too, assigns the lot of the individual a place in the destiny of a larger group, a collective. In the Abrahamic religions, collective eschatology occupies a prominent place alongside the image of individual salvation: For the chosen people the latter is linked with the collective salvific events of the end-time. On Christ's return to earth, all good people will follow him to heaven. That makes life, as well as people's ultimate destiny, by definition social.

But how do individual and social destinies relate? Here we find an apparent contradiction between collective and individual eschatology: It is not clear when a person is ultimately judged and redeemed. This might happen immediately after death or only at the end of time. In the latter case, the question is what happens to dead people between the time of their death and the end of time. These contradictions remain unresolved. What we have is two different versions of the afterlife of individuals and social groups. It remains a point of theological dispute. Islamic theology explains what happens to the dead after death until the opening of the graves as follows: After death, deceased people remain in a kind of sleep, from which they will wake in due course.

In recent Christian theological trends like liberation theology, the social aspect is heavily emphasized. God's presence transforms the here and now on earth, including people's social coexistence. In the face of all threats to creation and every injustice, God will ensure that the world attains a good future. Because of the salvation of Christ, even the natural evolution of the world will go the right way. More especially, the political and social world can take a positive turn through God's intervention.

Alternative Eschatological Notions

Apart from the collective eschatological notions in Abrahamic religions, there are many other variants. Some apocalyptic groups have end-time scenarios predicting a more negative prospect for humans and the earth. Some groups calculate the exact time of the end of the world and direct their lives wholly to that hour. This may be associated with a negative impulse for life on earth: Earthly life is not considered worthwhile because its end is approaching. But by and large, eschatology represents an attempt to infer a positive impulse for human life in terms of the question about the end-time. That applies particularly to the way death is handled. Eschatological notions, both personal and collective, are attempts to impart meaning to the end of an actual life that forms part of earthly reality and will eventually be part of divine or transcendent reality at the end of time.

Thomas Quartier

See also African Beliefs and Traditions; American Indian Beliefs and Traditions; Ancient Egyptian Beliefs and Traditions; Australian Aboriginal Beliefs and Traditions; Buddhist Beliefs and Traditions; Christian Beliefs and Traditions; Confucian Beliefs and Traditions; Daoist Beliefs and Traditions; Eschatology in Major Religious Traditions; Hindu Beliefs and Traditions; Jewish Beliefs and Traditions; Mesoamerican Pre-Columbian Beliefs and Traditions; Muslim Beliefs and Traditions; Shinto Beliefs and Traditions

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Eschatology in Major Religious Traditions

The concept of eschatology, or the study of the last days, is derived from the Greek words *eschatos* and *logos*, the combined meaning of which is the study of the end or last things. Thus, it refers to the final events in religious history or the history of the end of the world. Eschatology can be a symbolic end to material reality and the reunion with God. This may also refer to the end of a religious cycle or age by the return of a manifestation of God or Messiah in the end-time.

Many contemporary religions and cults promote fear of an apocalyptic end of the world, a

literal destruction of humanity and the earth. Other religions view the end as a gate to a new religious era. This entry discusses these issues in the context of the major religions of the world.

Bahá'í Eschatology

The Bahá'í faith is the newest world religion and second only to Christianity in its worldwide presence. A Bahá'í is a follower of the 19th-century "manifestation of God" named Bahá'u'lláh. Bahá'ís believe in a twin manifestation and forerunner to Bahá'u'lláh who took the name the Bab (the Gate). The Bab's ministry ended with his miraculous martyrdom witnessed by thousands in the city of Tabriz. Bahá'u'lláh fulfills prophecies from past world religions about the return of their messenger in the latter days to gradually usher in God's kingdom on earth. Bahá'u'lláh represents the Promised Lord of Hosts for Jews, the Immaculate Manifestation of Krishna for Hindus, the Buddha of Universal Fellowship for Buddhists, the return of the World Savior for Zoroastrians, the return of Jesus for Christians, and the Great Announcement for Muslims. His teachings and administrative order form the foundation for the gradual enfoldment of a future world theocracy based upon the best elements of governments. His coming fulfills prophecies symbolically represented by such language as the day of judgment, the resurrection of the dead, or end of the world.

Bahá'ís believe in the oneness of God and his manifestations, including Moses, Buddha, Krishna, Zoroaster, Muhammad, the Bab, and Bahá'u'lláh. All world religions contain a commonality as evidenced by the belief in the "golden rule," reward and punishment, the existence of heaven and hell, and the struggle between good and evil. Bahá'ís believe that contradictions in their dogmas and beliefs of various world religions are due to human misinterpretations and/or misquotations by religious leaders and scribes representing them.

Some of Bahá'u'lláh's spiritual teachings for this new era are the reality of heaven (closeness to God) and hell (remoteness from God), the efficacy of prayers for the dead in assisting the soul's progress in the afterlife, the harmony of science and religion, universal weights and measures, the elimination of all prejudices, the equality of men and women, universal auxiliary language, universal education, and the gradual development of a world theocracy spawned by global unity.

Buddhist Eschatology

There are three ways in which Buddhism exhibits a concern for final events: personal eschatology, cosmic eschatology, and cultural eschatology. First, Buddhism at its very essence is directing the adherent to achieve a personal end to the experience of *samsara*, or the cycle of birth, death, and rebirth. Engaging in ethical and meditative practices brings the adherent to a state of realized *nirvana* (a state of extinguishing of desire). After Buddha was enlightened, his first sermon was about the Four Noble Truths, which relate to the suffering, origin, cessation, and the path leading to cessation. The first Noble Truth indicates that life is a state of *dukkha* (suffering); the second Noble truth states the source of this suffering is desire. The third Noble Truth recognizes a state of no desire (nirvana), which is a state of nonsuffering. The fourth Noble Truth identifies a path to follow in extinguishing desire (*tanha*). Buddha called himself the Awakened One.

In Mahayana Buddhism the eschatological goal of realization is to become a *bodhisattva* rather than to become an *Arhat*, which is the ideal striven for by a Theravaden Buddhist monk. It is not just freedom from suffering that holds the key to a personal realization, but there must be a compassionate involvement with the lives of others and commitment to their awakening. The personal end of nirvana is postponed as the bodhisattva remains in this world to assist others to realize nirvana. One such example is Sakyamuni Buddha, who, after his awakening, became a teacher and counselor for 40 years.

The second way Buddhists view the end things is through the belief that there are cycles of manifestation and unmanifestation. The cycle of manifestation will come to an end and a cycle of unmanifestation will begin and end, and then a new cycle of manifestation will begin. This is cosmic eschatology, or a reflection of the natural order of things. In each phase of manifestation the beginning is marked by perfection, but perfection degenerates into imperfections such as immorality, sickness, and war. Human behavior creates the cycles and drives the movement toward an end to the cycle. A complete cycle is called a great eon.

Buddha thought the urgency of dealing with the problem of suffering did not leave a person time for speculation. He was a healer and a pragmatist who wanted people to be free from suffering. The foundation of Buddhist thought is based on conditioned reality, namely, that all things are conditioned and hence must pass away; even the phenomenon of manifestation must too pass away. Thus, understanding and accepting the conditioned nature of manifestation is essential to eliminating suffering. At the center of Buddhist insight is the conviction that ignorance is the source of all suffering; hence ignorance of the conditioned nature of manifestation is responsible for all suffering.

The third way in which Buddhism addresses final things is referred to as cultural eschatology. All things are conditioned and hence not unchanging and eternal, meaning that Buddhist teaching (*dharma*) is conditioned and hence is not an unchanging dogma. So there is a teaching in Buddhism that Sakyamuni Buddha's dharma, or teaching, will also come to an end. Buddhist teaching is founded by a particular individual and is conditioned by a particular culture and community of adherents who live in particular social circumstances. Human beings make mistakes, and hence the tradition itself is fallible. So Buddhist teaching cannot be unchanging and will then, at some point, pass away and be replaced by a new dharma. In early Buddhist thinking the belief existed that Buddhist teaching would fade away after 500 years. With the passage of the first 500 years, it was projected that Buddha's teaching would last 1,000 years. But that timeline has also passed, and new ways of interpreting the core belief into the conditioned nature of Buddha's dharma have arisen.

A well-established tradition exists that projects the appearance of a new Buddha once Sakyamuni Buddha's teachings are forgotten. Identified as Maitreya, the calculations for his appearance range in the billions of years from now. The prophecy predicts that Maitreya will attain bodhi within 7 days and will usher in a true dharma that will bring worldwide peace and harmony.

Christian Eschatology

Christian eschatology had its beginning in the early church's experience and expectation that Jesus Christ, after having died, resurrected, and ascended, would return in the future to bring about the end of the world, ushering in a new and lasting kingdom of peace. Early Christians believed that the *Eschaton* (end-time) was near and expected Jesus to return in their lifetime. When this did not happen, many new interpretations of the Eschaton arose.

Apocalyptic eschatology has its origin in the Hebrew scriptures in times when the righteous were suffering undeservedly while the unrighteous thrived. This state of affairs calls God's justice into question. Apocalyptic eschatology arose in order to project a future time in which God's justice would be realized and this trend would be reversed. Apocalyptic literature foretold an end of the world and a coming of the reign of God. Jesus was well aware of these apocalyptic voices and, in passages like Luke 11:20 and Luke 17:20–21, affirmed a prophetic eschatology. In these verses, Jesus is not foretelling a future event but rather a current event in which the demonic world of the sinner is shattered. He proclaimed God not as the one who ends the world but rather as the one who shatters this interpretive world in order to bring it under his kingship. The prophets proclaimed God's presence in the world. Prophetic eschatology announces that God is already present and tells where and how he is present. There are also passages where Jesus foretells an apocalyptic end to the world (Matt. 24), and so both traditions have ensued.

These two types of eschatological visions are found in some current thinking. Apocalyptic eschatology can be found in some Protestant debates about premillennialism, amillennialism, dispensationalism, and preterism. Although most Protestant churches are amillennialist (i.e., they hold that the rule of Christ has already begun), there are a significant number of churches that are premillennial and dispensationalist. Seventh-day Adventist eschatology is premillenialist because the membership believes that Christ's Second Coming will precede the 1,000-year rule of Satan on earth. Dallas Theological Seminary is considered the leading advocate of dispensational eschatology, which holds that different dispensations have defined humans' obligations to God. As far as the end-time is concerned, there will be a dispensation of a kingdom age after Jesus returns and the tribulation ends. Premillenialism is preached from most Baptist pulpits, but reformed eschatology tends to be amillenialist. Presbyterian

churches tend to be postmillennialist, which holds that the millennium has already occurred.

Premillennialism and dispensationalism are based on apocalyptic passages in the scriptures (Matt. 24, the book of Revelations, and 1 Thess. 4:16–18) and hold that there will be a second coming of Christ. The forces of evil are overcome, and finally a day of judgment occurs in which the person will be judged worthy of heaven or hell.

Some Church of Christ congregations embrace preterism in objection to scriptural literalism that is taking place in the previously described apocalyptic eschatologies. Preterism is the belief the events that are prophesized have already occurred in the New Testament era. The war of Armageddon is believed to have occurred during the late 60s and early 70s C.E., when the Jewish Temple in Jerusalem was destroyed. So when Jesus was teaching about the coming of the end of the world, he did not mean that the world would be destroyed but rather the world of the Old Testament and the belief that only Jews were included in God's plan of salvation. This position is further divided between full preterism and partial preterism, which holds that not all of the prophecies in the New Testament have already been realized.

The Catholic Church has traditionally been amillennialist in its views, although it does not use this term. Beginning with St. Augustine, the Catholic Church has affirmed the presence of the final age as having already been inaugurated by Christ. The Vatican II Council (1962–1964) affirmed this view and held that the restoration of the world had already begun in Jesus, is being carried forward through the Holy Spirit, and continues in the church. Vatican II documents call the Catholic Church the "pilgrim church" to indicate that it is on the way to transforming the present world to be in Christ's image. The Catholic Church holds there is an afterlife of heaven or hell or purgatory where sinners are purified; it also professes the return of Christ, the resurrection of the dead, the universal judgment, the communion of the saints, the existence of angels, and the suffrages of the dead.

Hindu Eschatology

Two concerns for end things are found in Hinduism. The first concern delineates a personal eschatology as well as a cosmological eschatology. The two complement one another as both comprise repeated cycles. A personal eschatology is found in the doctrine of *samsara*, a cycle of birth, death, and rebirth. Hindus believe that this cycle is one of difficulty and suffering. One escapes this cycle by becoming enlightened (*moksha*). This cycle is driven by *karma*, which is the natural law of consequences of sowing what you reap. Bad deeds result in the accumulation of bad karma, and this karma is carried over into a new reincarnated life after death. Good deeds accumulate and carry over as well and determine what kind of life form one will experience in the reincarnation.

Hindus hold that there is a true self (*Atman*), which persists in death and is reincarnated in a new body. To escape this cycle of karma-driven birth, death, and rebirth, Hindus believe they must come to the realization that their Atman is really one with Brahman or universal reality. This event of moksha will release the Hindu from the endless cycle of samsara. Although these beliefs can be found in the Vedas, which are the primary Hindu scriptures (*Shruti*), they can also be found in *Smriti* literature such as the *Bhagavad Gita*.

Correspondingly, the *Puranas* contain a clearly defined cosmological eschatology. These Smriti texts portray a cyclical universe that engages in 1,000 cycles of deteriorating ages during which the world is dissolved and recreated. Each cycle (*kalpa*) of creation and destruction is made up of 2,000 *mahayugas*. Each mahayuga is constituted by four ages or *yugas: Krita, Treta, Dwapara,* and *Kali*. Most Hindus believe that the current age is in the Kali yuga, the age of darkness, and this final age is the most degenerated. Each cycle begins with a golden age, but degenerates into war, decadence and immorality. When virtue and religion are practically nonexistent and humanity overwhelmed with evil, a 10th and final avatar of Vishnu will be born. This incarnation will be called Kalki and will ride on a white horse wielding a flaming sword. In a time span of three nights he will destroy all evil human beings, vanquish death, restore the true dharma, and reconcile opposites, while preserving the righteous few. Kalki will then usher in harmony and peace in a new era of Krita yuga. This new golden age will begin another cycle of yugas. This age will then digress from the state of perfection to decadence to complete another cycle.

Finally, after 1,000 cycles of deteriorating ages, the entire cosmos will dissolve including the world, gods, and demons, while all energy is absorbed by Brahma (God). Following this, chaos will prevail. Brahma rests during this phase until it is time for a new creation and a new cosmos is born of a cosmic egg.

Jewish Eschatology

Three main directions of eschatology can be perceived in Jewish traditions. First, there is a messianic eschatology that looks forward to a time in which Israel will be redeemed and restored. Second, there is a belief in an afterlife during which souls commune with God. Finally, there is a belief in the resurrection of the body, after which it is reunited with the righteous soul. There are distinct differences in the way these beliefs are understood, however, within Orthodox, Conservative, and Reform Judaism.

Hebrew scriptures portray an intimate relationship between *Yahweh* (God) and his people, namely the Hebrews, the Israelites, or the Jews. In the beginning, Yahweh created the earth good, but humans introduced sin and injustice. Yahweh acts then in history to save his people and call them back to him. He enters into a covenant with them and they are to follow his laws. When they do, each will be blessed, but if they do not, then curses will descend upon them. Scriptures describe how the people fail repeatedly, and then the idea arises that they need a king. Yahweh gives them a king, but even the kings they receive are weak and sinful. The 10 tribes of Israel are dispersed and assimilated among the Assyrians. Later the people of Judah are carried off into the exile in Babylonia. Out of the postexilic scriptures such as in Isaiah (24–27), Ezekiel, and Daniel (7–12), an eschatological messianism arose. There is hope for a "Day of God" when a ruler descended from the line of David will come and establish God's rule upon the earth and the righteous of Israel will be restored and redeemed. This Messiah (*Moshiach*) will be the *anointed one*, chosen to bring judgment on the enemies of Yahweh (both Gentile and unfaithful Jew). The Messiah will be heralded by great signs upon the earth. The Messiah will also bring about the unification of the divided Kingdom of Israel. The Temple in Jerusalem will be rebuilt, and the ancient form of sacrificial worship will be restored. The whole world will worship one God, weapons of war will be destroyed, and death will be swallowed up forever. Peace and joy will reign.

Orthodox Jews still hold as a tenet that a personal Messiah will come some time in the future. Conservative Jews, however, believe in a messianic age rather than a personal Messiah. Reform Jews hold that in this messianic age, reform and redemption will take place, but there will not be a personal redeemer.

Given the inequities of this life and the ancient Israelites' experience of unjust suffering, Judaic ideas of resurrection and afterlife arose in the Maccabean period. The afterlife, *Olam Habah*, is a time when souls are disembodied after death, and the righteous souls commune with God. Unrighteous souls are thought to be in *Gehenna*, which is a word taken from the name of the valley of fire where children were sacrificed in burnt offerings. Sometimes the afterworld is referred to as *Sheol* (grave). The unrighteous are not thought to spend more than 11 months in Gehenna in order to be purified. Thus, the *Kaddish* (memorial prayer) is recited for only 11 months. Orthodox views on the afterlife are strongest among Conservative Jews, while Reform Jews tend to be this-worldly.

The ancient Pharisees held to a belief in bodily resurrection. Passages in the Hebrew scriptures support this belief, for example, those found in Ezekiel 37, Daniel 12:2, Job 19:26, and Isaiah 26:19. Conservatives remain divided on the issue, and Reform Jews outright reject bodily resurrection.

Islamic Eschatology

In Islam, death ends physical life and the beginning of a period of rest until the day of resurrection when human souls will enter heaven. On that day God will judge the living and the dead. Muhammad, the prophet of Islam, is said to have ascended to heaven to visit the seven heavens (in some accounts, hell as well). Muslims believe that the final end of a person's life will be heaven or hell.

In Islam one's deeds play an integral part in forming one's spiritual condition, salvation, and station in the afterlife. Behaviors are never without consequences—be they corporeal, spiritual, immediate, or deferred. Accordingly, consequences involve

an interaction of various factors, such as one's intentions, will, and penitence. Every factor surrounding and including one's deeds shall be judged. Furthermore, one's actions are, in a way, a token for increased spiritual awakening within the lower realm of this world; this is because there is constant flux of interaction between one's spiritual and psychological states with behavior. Good behavior is not necessarily motivated by the prospect of salvation but is more a vehicle for journeying closer to God. In Islam emphasis is assigned to the moment of death, when one's faith should not waiver. Hence, faith at the moment of death plays a crucial role in one's position in the afterlife. The crux of eschatology lies in part in the sequential transmigration of souls in the afterlife after experiencing earthly trials and suffering. Death can offer a release from this suffering via the eternal joy of paradise.

A soul's ultimate destination is either heaven (reward) or hell (punishment) wherein one would dwell eternally. The afterlife is multifaceted, featuring many levels, differing in intensity. Heaven is seen as a realm built under an infrastructure that is distinctly different from this world and is a condition graphically portrayed as glorious and eternal. Hell is a fiery realm where evil persons are punished. Evil persons have visions of hell. Except for these visions, the soul remains in a kind of soul sleep until Judgment Day, when everyone is judged according to their deeds. Many Muslims believe that non-Muslims can attain heaven only after experiencing the purifying fires of an intermediate condition of purgatory—similar to Zoroastrian and Catholic beliefs. In this Day of Judgment, the Qur'an invokes a calamity that implies some kind of radical transformation of life.

Cosmic eschatology is addressed in one of the six articles of faith of Islam. Like some fundamentalist Christians, Islam teaches that the dead will be bodily resurrected. Hence, the body dies and decomposes, but the soul lives on. Salvation comes to the righteous and damnation to the wicked. Islamic eschatology is focused on the Last Judgment, the end of the world, and the coming of a world Savior, who will then fill the earth with peace and justice such as never before achieved. Shi'ites believe that al-Mahdi will reappear when the world has fallen into chaos and civil war. The Mahdi comes wielding the double-bladed sword. Sunni differ, with some believing that Jesus will return and others thinking the Mahdi will be an ordinary man.

Islamic eschatology of Muhammad has been divided into major and minor signs. The former includes the rising of the sun from the West, descending down of Jesus, the appearance of Yajuj and Majuj, and three sinkings (or caving in of the earth): one in the East, another in the West, and a third in the Arabian Peninsula. The last (sign) will be that of the fire that will start from Yemen and drive the people toward the place of reckoning.

Zoroastrian Eschatology

Zoroastrian eschatology is concerned with final things, that is, the advent of the Savior to defeat evil and the end of the world—a necessary conclusion to the creation story. Zoroastrianism (1800–1500 B.C.E.) is possibly the oldest religion. Zoroastrians (Zardishti) are followers of the Messenger Zoroaster. This dualistic religion believes in two opposing forces. There is one universal, transcendent God (Ahura Mazda) and his angels. In opposition is the demonic figure of Angra Mainyu, who is aided by evil spirits (Daevas). The world and all that was good was created by Mazda. Any worldly corruption is an effect of Angra Mainyu's influences. The Avesta (including the Gathas) is the holy book of Zoroastrianism which includes eschatological passages. Zoroastrian magi (priests) appear to have been the main augmenters of apocalyptic conceptualizations. Zoroastrianism has links to both Western and Eastern religions.

The Avesta has three eschatological themes: individual, universal, and apocalyptic. Mazda's creation involves the conflict between good, truth, and order and is the opposite of evil, falsehood, and disorder. One's free will to choose behavior determines where the person goes after death. Deeds, not beliefs, determine salvation in the afterlife. Zoroaster spoke of the fate of the dead. After 3 days comes the separation of the soul from the body. Every soul is first judged. Good souls are assigned to heaven (Infinite Lights) across a spiritual bridge of separation. Evil souls will be vexed at the Bridge of the Compiler and assigned to hell (House of the Lie) for eternity. Souls undeserving of heaven or hell go to an intermediate area called limbo (e.g., similar to Catholic purgatory). To

reach a succession of increasingly "infinite lights" requires the person to possess pure thoughts, words, and deeds.

Universal and apocalyptic eschatology described in the Gathas is dominated by an idea of fire. Good souls at the end of the world will be separated from the evil ones by a torrent of molten metal (for purification of all—including the sinners). At that time, the last judgment takes place. Life and the world will be transformed then. Through a ceremony, the dead will be resurrected with indestructible glorified bodies.

Finally, Zoroastrianism makes a distinction among (1) the fates of human souls after death and of humanity at the end of the world, (2) the various heavenly habitats which the souls are assigned to after death and the division of humanity after the final judgment, and (3) the events leading to the final end of the world after it becomes a new earth. Like most world religions, it's a millennial religion. There are three future saviors to come at different stages in history after Zoroaster. The first two (he who makes truth grow and he who makes reverence grow) prepare humans and the world for the final Messenger or Savior (he who embodies truth), who ushers God's kingdom on earth.

Christopher J. Johnson and Holly L. Wilson

See also Apocalypse; Armageddon; Eschatology; Hell; Last Judgment, The; Resurrection

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Estate Planning

Estate planning is the process by which an individual transfers property to his or her heirs and other beneficiaries while minimizing the associated costs and taxes. Estate planning can also ensure that one's financial and medical matters are handled as desired after incapacitation or death. An estate is the total property owned by an individual prior to distribution through a trust, will, or based on state intestacy laws. The process of estate planning, which is the focus of this entry, includes taking an inventory of all assets, discussing important decisions with family members, such as who will serve as the guardian for any minor children, making a will and/or establishing a trust, and considering a living will, power of attorney, and life insurance. Many individuals also create estate planning strategies to minimize the estate taxes they pay. The issue of estate planning applies to all individuals, as every individual will eventually face death.

The first step of estate planning is taking an inventory of all assets, including residential property, other real estate, savings, investments, pensions and other retirement accounts, life insurance policies and annuities, business ownership interests, motor vehicles, jewelry, collectibles, and other personal property, and assigning a value to each asset. Professional assistance may be needed to assign realistic asset values. The main reason that every individual needs an estate plan is beyond the factor of taxes. Benefits of estate planning include making sure assets go where one wants them to after death, controlling assets while alive but incapacitated, minimizing the emotional and financial burden on survivors, minimizing feuds among survivors regarding one's estate, increasing the amount available for charitable donations, avoiding the cost and time of probate, and providing terms for a guardian of minor children.

Many people avoid or delay discussing estate planning for several reasons. Many do not want to face a subject that is related to mortality. Discussions of estate plans may lead to family conflicts, and many individuals do not want to discuss money with their successors. Many individuals are also hesitant to invest the time and money required to create an estate plan. The lack of an estate plan can lead to increased taxes in addition to unnecessary conflicts, anger, and confusion among the survivors, and it can also require more of the survivors' time. Individuals are encouraged to have a minimum of four estate planning tools, including a will and/or trust, a living will, a medical power of attorney, and a durable power of attorney.

Wills

A will is a legal document that specifies the transfer of one's property and assets after death, and its main purpose is to ensure that one's assets go to designated family members or other beneficiaries. About half of all Americans die without having a will, which means that the court distributes the decedent's property according to state laws, which may or may not coincide with the decedent's wishes. If an individual has no apparent heir, which is one whose right to an inheritance cannot be voided or undone except by exclusion under a valid will, it is possible for the state to claim the estate.

Probate is a legal term and involves proving a will. During probate, the court determines whether a signed will is a genuine statement of how the decedent wished the estate to be distributed. The probate process may take a few days or several months depending on the state of residence. The complexity of the will affects the expense of the probate process. Careful planning can be used to expedite or avoid the probate process.

Each state has specific requirements for a valid will, but a will can generally be written by any individual over the age of 18 who is mentally capable. For a will to be valid, it must comply with the laws of the state in which one lives. Only about half of the states recognize wills not drafted by a legally trained person. State laws may also require the usage of specific language, a particular form of signature, and/or a specific number of witnesses of a certain age when the will is signed. A will is also used to designate a guardian for minor children in the event of the parent's or guardian's death, without which the court may appoint a guardian.

Basic elements of a will include the individual's name, place of residence, and description of assets; names of spouse, children, and other beneficiaries, as well as names of alternate beneficiaries; specific gifts; establishment of trusts; cancellation of outstanding debts owed to the individual; names of a guardian and alternative guardian for minor children; name of the estate executor; and the individual's and witnesses' signatures. The executor is the person who executes the instructions in a will. This individual must be able to handle all of the financial matters involved with settling an estate. Some states require the executor to be a state resident. An executor is responsible for collecting the decedent's assets, paying creditors, paying taxes, notifying Social Security and other agencies, cancelling credit cards, and distributing assets according to the will. Being an executor is time-consuming, and executors are generally paid for their services.

Trusts

Trusts, as opposed to wills, eliminate the need for probate, which is a lengthy and costly process that oversees the transfer of assets. Trusts are also sometimes used to make gifts while the donor is still alive in order to minimize taxes. When a living trust, a device in which an individual holds

property as a trustee, is made, the surviving beneficiaries can transfer the property quickly and easily. The two most common types of living trusts are (1) a basic living trust for an individual or couple, which avoids probate; and (2) an AB, or credit shelter trust, which avoids probate and also reduces estate taxes. To create a basic living trust, an individual, called the grantor, transfers ownership of some or all property to the living trust. A person is named in the trust document to take over the trust after the grantor dies. A credit shelter trust lets a couple pass the amount of property to their beneficiaries after both spouses die while ensuring that the surviving spouse is financially stable during his or her lifetime. Rather than leaving property outright to a surviving spouse, each spouse leaves the property to a credit shelter trust and names final beneficiaries. When one spouse dies, the surviving spouse can use the property with certain restrictions but is not the outright owner of the property. Therefore, the property is not subject to estate tax when the second spouse dies, because the second spouse was never an "owner" of the property.

Living Will

A living will is an advance health directive, or a written declaration of what life-sustaining medical treatments an individual will allow or not allow in the event of incapacitation. It is a legal instrument and is often notarized or signed in the presence of witnesses. In a living will, for example, a person may request that he or she is not resuscitated in the case of cardiac or respiratory arrest. Family members and medical institutions often challenge the meaning or validity of living wills, so considerable care and specify are required when creating such documents.

Medical Power of Attorney

A medical power of attorney is a document authorizing a person, or agent, to make medical decisions on behalf of another individual, the principal, ultimately to carry out what the principal specifies in the living will. The medical power of attorney is effective indefinitely, unless a termination date is specified. The agent makes health care decisions for the principal only in cases in which a physician certifies in writing that the principal is incompetent. The agent should be a trusted person who understands the wishes of the principal and who will be strong enough to carry out those wishes although other family members or survivors may object.

Durable Power of Attorney

A durable power of attorney is a document for estate planning that enables an agent, or a named representative, to act for the principal, or the person drafting the document, after the principal becomes ill, incapacitated, or unable to make decisions. It allows an individual to select another person, such as a spouse or adult child, to serve as a representative, performing certain actions in specific cases, such as incapacitation. That representative can pay bills or make major financial decisions on behalf of the principal, depending on the limit of the powers. Without a durable power of attorney, an individual's spouse or other family members would need to seek approval from the court to carry out financial transactions. The durable power of attorney is effective until it is revoked by the principal or until the principal's death. In some jurisdictions, a living will and durable power of attorney are considered to be the same thing.

Life Insurance

For those who have dependents they wish to support in the case their own death, life insurance is an important part of estate planning. Life insurance is a contract between the policy owner and the insurer, where the insured pays a specific amount each period, called a premium, and in return, the insurer agrees to pay a certain amount of money upon the insured's death. In the United States, life insurance contracts generally specify a lump sum to be paid to the beneficiary in the case of the insured's death, while different trends are followed in other countries. Specific exclusions are written into life insurance policies to limit the liability of the insurer, such as no payment of benefits in the case of suicide, fraud, or war. Within estate planning, life insurance can have several functions, first of which is to provide family protection in the case of premature death. Such policies can also be used to protect the assets in one's estate from catastrophic loss or lawsuits, as an asset to pass on to

others, or to pay for estate taxes. Small business co-owners often use life insurance policies to buy out the deceased's portion of the business.

There are two types of life insurance policies: term and permanent. Term life insurance provides life insurance coverage for a specified number of years for a specific premium, whereas permanent life insurance continues until the policy is paid out or the owner fails to pay the premium when due. The proceeds from a life insurance account are not subject to income tax, but they may be subject to estate tax.

Minimizing Estate Taxes

Estate tax rates and the complexity of the estate tax system have led to a vast amount of support services to assist individuals with perceived eligibility for the estate tax to minimize their required payment. There are a number of estate planning methods that are used to minimize the federal taxes on one's estate. The marital deduction can be used to transfer any amount of assets to a spouse without being faced with gift or estate taxes. However, marital deductions may increase the total combined federal estate tax liability of the spouses upon the death of the surviving spouse. An AB trust can be used to avoid this issue, as this instrument combines the tax exemption limits for a husband and wife and gives the couple the advantages of the marital deduction while utilizing the applicable credit to its maximum.

Another method is giving away assets during one's lifetime rather than waiting until death to transfer such assets. Federal tax law allows individuals to give up to a certain amount every year to any other individual, subject to certain restrictions, without paying gift taxes. In this way, a portion of one's wealth can be transferred to others prior to death with no tax payments required. Charitable gifts are frequently discussed when covering the issue of estate planning. Charitable gifts are not taxed provided that the contribution is made to an organization that operates for religious, charitable, or educational purposes, and is viewed as eligible by the Internal Revenue Service. Estate tax deductions are given for donations to qualifying charities.

Life insurance trusts are another instrument to minimize federal estate taxes. Life insurance trusts can be designed to keep the proceeds of a life insurance policy out of one's estate and also provide one's estate with liquid assets. A life insurance trust can generally be funded by transferring an existing life insurance policy, which may have tax consequences, or by having the trust purchase a new insurance policy. The life insurance trust must be irrevocable in order to avoid inclusion in one's estate.

Patti J. Fisher

See also Economic Impact of Death on the Family; Estate Tax; Life Insurance

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Estate Tax

The estate tax is a tax on one's right to transfer property at death and is paid on the contents of the deceased person's taxable estate. The U.S. federal government taxes wealth transfers through its unified gift and estate tax system, which is composed of two parts: an estate tax and a gift tax. Whereas the estate tax is imposed on the transfer of property after death, the gift tax applies to transfers of wealth between living persons. The U.S. Congress has created uniform tax rates for gifts and estate transfers of wealth, but different tax credits have been provided for gift and estate taxes since 2002. The U.S. federal estate tax

applies to every decedent who is a citizen or resident of the United States. Most individuals have heard of the estate tax, but many do not understand this death-related concept. This entry includes discussions of the estate tax in the United States, the history of the U.S. estate tax, the ongoing debate regarding estate taxes, and information on estate taxes in the international arena.

To calculate the estate tax, the gross estate is first calculated by adding the fair market value of all assets owned and interests in assets at the date of death, including cash and securities, real estate, insurance, trusts, annuities, business interests, and other assets. Second, certain deductions are allowed to arrive at the taxable estate, including mortgages, other debts, estate administration expenses, and property that passes to surviving spouses or qualified charities. Third, after the net amount is computed, the value of lifetime taxable gifts is added, and the tax is computed based on this number. The tax is reduced by several credits, including the available unified credit, which provides an exempted value with respect to the sum of the taxable estate and lifetime taxable gifts. If the estate includes property that was inherited within the previous years, and estate taxes were paid on that property, a credit may also apply.

In addition to the estate tax imposed by the federal government, some states also have an estate tax, with the state versions sometimes called an inheritance tax. Some states "piggyback" on the federal estate tax law—that is, estates exempt from federal taxation are also exempt from state taxation—whereas other states operate estate taxes independently of federal law, and estates may be subject to state tax but exempt from federal tax.

History of the Estate Tax

Historically, the federal government did not rely on such transfer taxes as a permanent source of revenue but as temporary sources of revenue during national emergencies, and the tax was generally repealed after the emergency had passed. The first transfer tax in the United States was enacted at the end of the 18th century when the nation was forced to develop a powerful navy as a result of strained trade relations with France. This led to the Stamp Act of 1797, which required the purchase of federal tax stamps when transferring property from an estate. This tax was repealed in 1802. Over 100 years later, in 1916, the Revenue Act passed, which created both the income tax and estate tax, and the gift tax was implemented in 1924 to prevent avoidance of the estate tax.

The federal transfer tax system was modified in a series of legislation passed in 1976, 1981, and 1986. Portions of the separate estate and gift tax systems were unified, marginal transfer tax rates were reduced, and filing requirements were increased, which resulted in a reduced number of transfer tax returns filed each year. Some of the changes made in this series of legislation were partially reversed in 1987 and 1992, reinstating the two top marginal rates on transfers. The estate tax was temporarily phased out by the 2001 Economic Growth and Tax Relief Reconciliation Act, with the estate tax rates set to return to the pre-act rates in 2011.

Estate Tax Debate

The estate tax continues to be an issue of heated debate. Proponents argue that federal government needs the revenue and that the estate tax provides a better source of revenue than the income tax. This is because the income tax is believed to provide disincentives to work, as it does not tax money that the individual spends, but that which is given away for noncharitable purposes. Supporters of the estate tax also argue that it helps to prevent the continuing passage of wealth in families, free of tax, contending that the estate affects only the top percentage of the wealth distribution and provides a number of credits that allow even large estates to escape taxation. Advocates of the estate tax also argue that it encourages charitable giving, as this is one way for individuals to avoid paying the tax, and according to a Congressional Budget Office Report released in 2004, eliminating the estate tax would reduce charitable giving by 6% to 12%. Supporters have also argued that the estate tax lessens income inequality.

Opponents of the estate tax argue that the tax obligation may overshadow more fundamental decisions about an individual's assets, possibly providing a disincentive to make wise investments. In addition, not all individuals have equal access to estate planning services, which may create an unequal tax burden. Research has shown that the estate tax may act as a disincentive toward

entrepreneurship and also imposes a large compliance burden on the U.S. economy, while being one of the most inefficient revenue sources. In addition, the burden of the tax falls on those receiving the property transfer, and the distributional effect of the estate tax is uncertain, as it is unknown whether the recipient is wealthy or poor.

International Estate Taxes

Many nations have lower tax rates on estates or inheritances than does the United States, which has the third highest estate tax rate in the world, following Japan and South Korea. Several countries, including Australia, Canada, China, India, and Mexico, do not have an estate or inheritance tax. The inheritance or estate tax is common in Europe, and in some nations, including Germany and France, surviving spouses are required to pay taxes on the deceased spouse's estate over a certain amount. In international tax law, the estate tax and inheritance tax are different, although this difference is not always respected, as the estate tax is a tax on the personal representatives of the estate, whereas the inheritance tax is a tax on the beneficiaries of the estate.

Patti J. Fisher

See also Economic Impact of Death on the Family; Estate Planning; Life Insurance

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Eulogy

A eulogy is a specialized form of public address that occurs within ceremonies and rituals held in honor of the recently deceased. Eulogies are important because they initiate the grief process of mourners. In so doing, they provide a variety of connections between the deceased and the survivors. The eulogy also often reveals as much about the eulogist as it does about the eulogized.

Marking the passing of a loved and appreciated person by way of a public speech within funeral and memorial services occurs in every civilized contemporary culture. Though a time-honored and widely accepted practice, popular and scholarly understanding of a eulogy's purposes and components continues to evolve. Once recognized as existing to praise and memorialize the deceased, eulogies now console both the audience and presenters.

History of Funeral Oration

Many societies across various eras have invoked rituals such as funerals to respond to the great mystery, fear, and awe that surround death and dying. While the majority of rituals pertain to handling and disposition of physical remains, ceremonial features are also prominent in the earliest stages of grieving. For over 100,000 years, death practices that include religious ceremony and oration have been created to inspire the passage of the soul into another spiritual realm. Burial sites from the Neanderthal period, located near present-day Iraq, yield tools and supplies indicating that the dead were equipped with such items for the journey into an afterlife.

The ancient Egyptians meticulously prepared corpses to ensure that the souls of the dead would pass on to the next world. Though much of the associated treatment such as embalming and mummification was physical in nature, language played a role via inscriptions on amulets and inside tombs. Funeral ceremonies commonly invoked nonverbal gestures, dances of grief, and incantations such as the Opening of the Mouth, designed to revive the deceased's senses for future use.

The term *eulogy* is derived from the Latin and Greek *eulogia*, meaning well speaking or giving of high praise. Predating the birth of Christ by at least 4 centuries, the Greeks celebrated a ceremony of public burial and funeral oration. The citizens of the city-state of Athens, recognizing those who had died in battle, expressed gratitude in the form of laudation within the funeral oratory. In his "Orations Against Leptines," Demosthenes noted

that the Athenians uniquely offered funeral orations to glorify brave men and their actions. In the Menexenus, Plato detailed the structure of the funeral oration form referred to as epitaphioi; he reviewed eulogizing of the dead, exhortation of their values, and consolation of their survivors. Political agendas have also been identified within Athenian funeral oratory. For example, *epaino* (praise of the city) was offered, as was idealization of democracy.

The ancient Romans also infused funeral oratory with memorialization as well as social and political advocacy. After funeral rituals, a relative of the deceased would recite his values, accomplishments, and service to Rome so as to honor the individual, the family, and the state. In so doing, the orator also endorsed a model of virtuous living. Though no direct record of Mark Antony's funeral oration for Julius Caesar exists, it is understood to have inspired mob activity that forced Caesar's slayers into exile.

Several other cultures developed symbolic acts and practices to accompany their death rituals. Until around 100 B.C.E., European Celtic funerals featured banquets and processions, including the hurling of spears into a grave. The Norse and Viking people grieved the elite by entombing them in their ships and casting them aflame. In the Eastern world, young Hindu widows joined the funeral pyre as it burned for their husbands. Japanese mourners would bathe to cleanse them of death's taint. In North America, the Maya painted comical and traditional figures on pottery to be buried with the dead. In South America, the Incas created huge mountainside tombs and elaborate ceremonies to honor both higher-class nobility and children sacrificed for the communal good.

The duration of stately funerals was enlongated during the Middle Ages as the death of royalty meant long and frequent Christian masses, multiple burials, and new reigns that demanded ceremonial inception. Sermons delivered during funerals supplemented memorialization with biblical representations of death and exhortation of prayer and assistance toward the dead's attainment of heaven. Also, with the enhanced need for funerals as determined by the ravages of plague and war, two eulogistic features developed. Standardized sermons were in use, though they could be adapted for the characteristics of a particular decedent and according to one's social status. Inevitably, survivors were encouraged to manage, rather than succumb to, their grief.

The Renaissance and Enlightenment eras brought various controversies, including the extent to which burials, funerals, and eulogies were religious versus civic or secular entities. By the 17th century, Protestant and Catholic positions on funeral sermons had settled roughly on a combination of scripture, allusion to brief life as opposed to extended afterlife, encouragement to live and die morally, and what was becoming the substance of the eulogy, a revisiting of personal details. During the ensuing centuries, especially in Western Europe, religious contributions to eulogistic texts moved from threats of hell for immoral lives to promises of heaven for those who lived a righteous life. Concurrently, emphasis on the individual at the expense of religious dogma continued to evolve, though slowly.

Throughout the 20th century the profession and industry of the funeral was affected by several societal developments. War and atrocity wrought ever more death even as life expectancy increases distanced most developed world citizens from their own perceptions of mortality. Also, a creeping secularism lessened belief in an afterlife and provided a sense of death as outright termination rather than mere expiration of the deceased's soul. The comforts and conveniences of modern life may also be said to have collectively inflated individual awareness and perceived self-importance to the extent that death became viewed as more atrocious and unfathomable than ever before. Although grief was acceptable, it was expected to be managed over a certain amount of time and with quiet dignity. Thus, extended periods of mourning created social awkwardness or stigma. And though death itself is a more prominent topic in popular culture, the associated marginalization of death-related rituals has inspired the funeral industry to adopt appropriate staging, cosmetic practices, and euphemistic language such as "resting place" and "at peace" that further shield survivors from the reality of death.

Contemporary Eulogy Characteristics

Memorial services and funerals largely continue to feature traditional religious components, but in an

era of both lower extent of religiosity in the general population and huge evangelical congregations, clergy that deliver eulogies are less likely to personally know the deceased. Family members and friends are increasingly called upon to provide details to clergy or to perform eulogies themselves. With greater diversity in eulogizers has come more variety in format and content of eulogies, including personal reminiscence, popular poetry, recitations of the deceased's creative endeavors, and musical selections. Nonetheless, scholars have observed some trends in the content of the contemporary eulogy.

As in years past, modern eulogists seek to honor, if not worship the dead, with the provision of effusive praise. In remembrance of his sister, Diana, Princess of Wales, Earl Charles Spencer labeled her "the very essence of compassion, of duty, of style, of beauty," and someone who was "a symbol of selfless humanity, a standard bearer for the rights of the truly downtrodden." Stanley Dance called Duke Ellington "a beloved friend" and "a genius of the rarest kind." Adlai Stevenson even compared Eleanor Roosevelt's public derision as a do-gooder to that of "another public figure 1,962 years ago."

Contemporary eulogists often say goodbye, indicate their love, and promise to remember the deceased. In his eulogy for the crew of the space shuttle *Challenger*, President Ronald Reagan said, "Dick, Mike, Judy, El, Ron, Greg, and Christa—your families and your country mourn your passing. We bid you goodbye. We will never forget you." The former prime minister of Canada, Pierre Trudeau, was endearingly dismissed by his son Justin, "Je t'aime Papa."

More than the attempts to secure an afterlife as witnessed in eulogies of past generations, 20th-century eulogists are more likely to include assumptions of the deceased's existence in an afterlife. Noa Ben Artzi-Filosof asked "the angels of heaven that are accompanying you now" to watch over and guard her grandfather, the assassinated prime minister of Israel, Yitzhak Rabin. Diane Sawyer knew that there was "laughter in heaven" with the ascension of Lucille Ball, and President George W. Bush told the world that one of the astronauts from the space shuttle *Columbia* knew that if he died on the mission, he would be "just going on higher."

The deceased are often represented as living on not in heaven but in the hearts and minds of their survivors. President Lyndon Johnson remarked that President "John Fitzgerald Kennedy lives on in the immortal words and works that he left behind." Schoolteacher Jeanette O'Day's son Alan told his audience that "when you miss her and you remember how much she touched you, she will live on. When you are merciful to an injured animal, when you teach peace and tolerance to a child, she will live on."

One underappreciated aspect of the modern eulogy is its consolatory nature. Though it may be temporary, some relief from grief for the bereaved is provided when eulogizers offer a reappraisal of the loss of the deceased. The distressing event is reconceptualized so as to be somewhat more acceptable. One way of providing a more positive perspective is to acknowledge gratitude for the times enjoyed with, and lessons learned from, the eulogized. President Bill Clinton asked us to "thank God today for the lives, the character and courage of the crew of the USS *Cole*." And of Mahatma Mohandas Gandhi, Jawaharlal Nehru said, "that light represented the living truth, the eternal truths, reminding us of the right path, drawing us from error."

Positive reappraisal of death may be presented simply as recognition of a life well-lived. Senator Edward Kennedy appreciated that his nephew John F. Kennedy Jr. "for a thousand days was a husband who adored the wife who became his perfect soulmate . . . he found his shining star." Frank Oz's entire eulogy for Jim Henson portrayed the muppeteer's unique ability to intensely appreciate his own work and its rewards.

Those in attendance at eulogies are often offered consolation in the form of opportunities to break the paralysis of grief by actually doing something good. A prayer and memorial service at Yankee Stadium after the attacks on the World Trade Center featured Reverend Calvin Butts, who urged, "Get back on the airplanes! Go back to work! Rebuild America!" Both presidents who eulogized the astronauts lost to space shuttle explosions urged the space program be continued in their honor. Earl Charles Spencer implored the British public to subject Princess Diana's sons to less intense media scrutiny than that which exasperated their mother. Indeed, the social and

political advocacy of ancient eulogists is sometimes echoed by their contemporary counterparts. One obvious context in which this occurs is the funeral and services for the famously assassinated. Eulogies offered for President John F. Kennedy, civil rights leader Martin Luther King Jr., Senator Robert Kennedy, and others called for the continuation of their causes and beliefs.

Eulogists may also work to repair their own grief by voicing their strong emotions at the loss of the deceased. Two days after the assassination of President Kennedy, Chief Justice Earl Warren admitted that "we are saddened; we are stunned; we are perplexed." Archbishop Desmond Tutu was "struck numb with disbelief" and grief and "groan(ed) with anguish" at the news of Stephen Biko's death.

In sum, contemporary eulogies exist as much for the benefit of survivors as they do to dedicate the memory of the deceased.

Michael Robert Dennis

See also Bereavement, Grief, and Mourning; Condolences; Funerals; Language of Death; Obituaries, Death Notices, and Necrology

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EUTHANASIA

Practices of euthanasia have been found throughout the cultures of the ancient Greeks, Greco-Romans, Judeo-Christians, and early modern times to the present-day developed world. A common form of euthanasia is traced to the Greek roots *eu* (good) and *thanatos* (death), which have been variously rendered over the centuries as "heroic death," "noble death," and "good death." The idea of a "good death" as painless, peaceful, dignified, and within the control of the dying individual has played a central role in both the reception and understanding of the practices of euthanasia in the contemporary United States and other developed nations. The main antecedents of the medical-moral-legal context for contemporary understandings of euthanasia are discussed in this entry, followed by a review of modern controversies.

Ancient Greek and Greco-Roman Worlds

Ancient Greek attitudes toward death evolved with conceptions of euthanasia as a good death. Homeric heroes are depicted accepting death as an unavoidable evil. Acceptance of battlefield death was a fact of heroic life, and the resignation toward death the highest expression of respect for heroic values. Concerned with his own glory, the hero abjured shame and met his fate in a good death, which was essential to his fame. Heroic death gave no place to doctors to assist the dying in their last moments, and no confirmation of death was necessary, for the hero died his own good death. The essential component of euthanasia in the hero's attitude toward the evil of death was his modeling of a good death crowning a good life.

Death in the age of the Greek city-state acquired a social significance for the commonwealth, which glorified individual solidarity in defense of the

state, and associated such nobility in dying for a greater good with heroic recognition and honor. Cooperative virtues supplanted competitive virtues of the older Homeric society. For a life of happiness lived in a flourishing city-state, the ultimate individual contribution to the well-being of the polis was to have sacrificed life in its name. Euthanasia, thereby, elevated the merits of citizenship and overshadowed the demerits of the individual in the golden age of community values exemplified by the city-state.

Medicine held a prominent place among cultural achievements in the era of city-states, with the influence of the Hippocratic school often memorialized in modern times. Characteristic of the Hippocratic attitude toward sickness and death was the orientation toward enumerating various etiologies of diseases via observation of symptoms of patients. Employing rational explanation to discern the causes of sickness distinguished these doctors as forebears of practitioners of scientific methods and principled investigation in the acquisition of knowledge of humanity. The Hippocratic practitioner, however, seems to have played little if no part in attempting to relieve the suffering of those who were fatally ill. Concern for the indicators of death was primarily pragmatic in that the doctor could prognosticate death and factor this into a decision of whether to accept a patient who was beyond the help of the medical art's limited resources.

Palliative care, in the modern sense of ensuring a gentle death, was not emphasized in ancient medicine. Nevertheless, contemporary medicine's appeal to a Hippocratic injunction to doctors to not give lethal potions to patients even if requested by patients is commonly referenced in discussions of euthanasia. This idea may be an inaccurate gloss of one school's code of conduct, whose actual context and concern was to ward off a criminal role for the doctor in the surreptitious killing of a patient at another's request (e.g., a family member's request). Even so, the Hippocratic school was only one of among many much more naturalistically oriented schools whose practitioners were less reluctant to assist those individuals who had already chosen a good death in suicide.

Attitudes toward death and practices of euthanasia under conditions of Hellenistic expansion and Roman imperialism became increasingly complex during the evolution of an increasingly cosmopolitan world. The major philosophical schools of Stoicism and Epicureanism exhibited cultural tensions common to various interpretations of death and euthanasia while also prefiguring elements of contemporary debates. Stoicism embraced a conception of the individual as world citizen where wisdom dictated acceptance of the natural vicissitudes of life, including facing sickness and death with firm resolve and moral perfection. Both Greek and Roman variants of this attitude toward life and death undergirded subsequent Christian views.

Epicureanism elaborated on pre-Christian conceptions of the nullity of death and the centrality to life of "hedonism" understood as a life of good quality. Largely antithetical to Christian belief, this view held that death was simply one of many natural changes undergone by all individuals, did not necessarily entail pain or suffering, and was acknowledged as the terminus of individual existence. Postponement of life's enjoyments was pointless, and longing for death was considered an unnatural preoccupation that bred common, if irrational, anxieties best denied by striving for the unperturbed life. *Carpe diem,* an attitude of "grasping the moment," entailed enjoying life to the fullest despite personal extinguishment in death. This Epicurean attitude can be traced in contemporary secular debates over euthanasia, particularly in the case of physician-assisted suicide.

Voluntary self-killing, thought to be permitted and sometimes glorified, especially among the Romans, was also an object of doubt and rejection. For example, the Pythagorean dualistic view of human nature held that the soul was ruptured from the body through the violence of suicide. Rather, the release of the divine element of the soul from embodiment through wisdom was counseled. The Epicurean naturalistic view of human nature recognized a fundamental right of individuals to dispose of their own lives as integral to their quality of life. Alternately, the emphasis was placed on the gravity of judiciously electing the final act of volition. Such ambivalence toward suicide made for a cautious approach to this form of euthanasia. Voluntariness and principled preparation were the hallmarks of this good death as exemplified in death by hemlock in the cases of both Socrates and Seneca. There is some evidence for the presence of a doctor as procurer of the poison at Seneca's request. Information as to the doctor's affiliation

with a school of medicine, in particular, the Hippocratic school, is lacking. What does not appear to be in doubt is that the assistance of doctors at the deaths of individuals who had chosen euthanasia in the form of suicide was not uncommon.

Judeo-Christian Legacies

Stoic and Pythagorean attitudes toward suicide became more entrenched in early Christian doctrines, for example, in the works of Augustine, who writes of self-murder as an affront to God. The theological basis for the sins of murder and self-murder was explicitly formulated by Thomas Aquinas in his Christianized natural law ethics derived from Aristotle. On this view, God created all things, and it was God's prerogative to both give and take human life according to a plan of redemption. The natural good of humanity consisted in (among other goods) respecting and facilitating the inclination toward self-preservation. Choosing euthanasia in the form of suicide usurped Divine authority and for most of church history, self-murderers were banished from burial in consecrated ground; this banishment symbolized their loss of a chance for salvation in the afterlife. The only "good death" was a God-given death ideally after a good Christian life oriented toward the last judgment. The Christian doctor was not to assist in suicide and to refrain from euthanasia, now narrowly circumscribed as murder of the patient. The doctor's role became associated with palliation of the death of the patient and provision of comfort to the patient's family in following the example of Christ Healer.

The medieval Jewish tradition, personified by Maimonides, provides a rich source for attitudes toward death and the physician's role in caring for patients and facilitating a "good death" in a God-centered world. On the Hebrew view, the Creator so loved the world that he created human beings in his image and, therefore, to destroy or damage any human being offended God and diminished creation. The importance of this for physicians is elaborated in Maimonides' prayer as follows: The doctor has been chosen by God in his mercy to serve him in caring for the life, health, and death of his creatures; the doctor prays for inspiration from God to deepen his love for his calling and for God's creatures so that all three parties will be well served; the patient's disease is a gift from God foreboding danger and counseling the doctor's wisdom to avert it; and, lastly, the doctor specifically prays to remove from his patients all those who would interfere with and frustrate the medical art even to the point of often leading God's creatures to their deaths.

Both Christian and Hebrew physicians consider the practice of the art to be a vocation in the service of God and his children. Common strictures govern the physician's role in that individuals are to be cared for in health, sickness, and death and steadfastly protected from those who would undermine patients' "best interests" according to the art, namely, those third parties represented by charlatans, meddlesome relatives, and presumptuous death dealers. Suicide was no longer equated with the freedom of a "noble death" as it was with the Greco-Romans; rather, the doctor acting to assist in suicide and to cause the death of patients committed sin. While Maimonides gives no specific instruction to the doctor to refrain from providing lethal medicine, unlike the common view of Hippocrates' instruction, the Hebrew tradition would certainly have made additional instruction to the doctor redundant. The Jewish doctor is specifically enjoined, as opposed to those in the Hippocratic tradition, to give God's creatures all possible help and comfort in their last hours. The Judeo-Christian covenant with God and patients absolutely obligates the physician-servant to preside over and palliate death, neither assisting the patient's death nor causing the patient's death.

Euthanasia in the Developed World

Understanding euthanasia within this framework reveals both continuities and discontinuities with contemporary conversations about death and dying in the United States, especially when appreciated within the international context of developed Western nations. The large time segments spanning the modern period through the Enlightenment (1600–1700s) up to the Industrial Revolution including the Victorian era (1800–1920s) have more in common with earlier modes of death and dying than with conditions in the contemporary developed Western world. Judeo-Christian values pertaining to death and dying and the proscription against a role for the physician in either causing or

aiding the patient's death generally coexisted in tension with Epicurean and later secular values upholding the individual's control over the manner and timing of death by recourse to physician-assisted suicide. Increasing professionalization of medicine and early modern advances in research and therapeutics notwithstanding, death and dying did not come under the effective control of physicians until the development of highly bureaucratic institutions of medical care in recent times.

People die differently in the developed world such that what remains from the Greek senses of euthanasia are an ambivalent notion of a "good death" and the idea of a "dignified death" as an individually directed death. Developed nations, such as the United States, the Netherlands, and Germany (among several others), are all advanced industrial democracies with sophisticated medical facilities and life expectancies over 75 years of age. Populations in these societies are all characterized by an increasing proportion of older individuals. All are experiencing what has been identified as the fourth stage of the epidemiologic transition, a stage of societal development in which acute death due to infectious disease has largely been replaced by diseases that generally entail a more protracted dying process. Some estimates are as high as 70% to 80% of the population dying from degenerative diseases that are characterized by late, slow onset and extended decline. Accidents, suicide, and infectious diseases like AIDS and influenza are still causes of death in the developed world; however, most people die from cardiovascular disease, cancer, diabetes, solid organ disease, or degenerative neurological disorders. The common problem of euthanasia is how to deal with the characteristic new ways in which people die.

Euthanasia and Issues in Medical Decision Making

Advances in medicine have greatly improved possibilities to treat seriously ill patients and to prolong life. There is increasing recognition that life extension may not always be the appropriate goal of medicine, and other goals must guide medical decision making at the end of life. Medical decision making for patients with life-threatening diseases increasingly entails a balanced consideration of medical, ethical, psychosocial, and societal aspects. These considerations and the legal background in each country may modify end-of-life decision-making practices and attitudes of doctors, patients, and other people involved. In principle, end-of-life decisions include the following: whether to withhold or withdraw potentially life-prolonging treatment, for example, mechanical ventilation, tube feeding, and dialysis; whether to alleviate pain or other symptoms with, for example, opioids, benzodiazepines, or barbiturates in doses large enough to hasten death as a possible or certain side effect; and whether to consider euthanasia or physician-assisted suicide, which can be defined as the administration, prescription, or supply of drugs to end life at the patient's explicit request. End-of-life decisions take place wherever patients die, including in hospitals, nursing homes, hospices, and at home.

Accounts of end-of-life practices and associated controversies in the developed world, in particular, one by Margaret Battin, report these general findings: End-of-life decisions that are mainly a response to the suffering of patients, including alleviating pain and ending life without the explicit request of the patient, seem to be practiced everywhere in modern health care, and the frequency of end-of-life decisions that are most strongly determined by cultural factors, such as the patient's autonomy, criteria for medical futility, or legal status (euthanasia, nontreatment decisions), varies much among countries. Battin's specific research notes that there are three basic models of dying, with one of each model exemplified by the United States, the Netherlands, and Germany. She attributes the main medical, moral, and legal controversies about a "good death" in the developed world to intercultural and intracultural differences among the basic models.

Current Controversies in Euthanasia

Decisions to forgo treatment have become ubiquitous in the United States while physician-assisted suicide (PAS) and voluntary patient request for administered death remain ethically controversial and illegal (with PAS illegal in only some states). The last 2 decades of the 20th century witnessed upheavals in public consciousness about PAS, beginning with the activities of Dr. Jack Kevorkian

in Michigan during the 1990s. "Dr. Suicide," as Kevorkian became known, publicly advocated PAS and ultimately assisted in approximately 100 deaths with his "suicide machine." Controversy surrounding Kevorkian's methods pertained to his acting in isolation from the medical community, his high jury acquittal rate on charges of PAS, and his public posturing in a state that did not have laws about PAS until its legal ban of it in 1993. Kevorkian was eventually imprisoned for several years (and was released in 2007) on conviction, not of PAS, but of homicide for administering a lethal dose of medication to a patient.

If Kevorkian represents the fringe element in assisting death, then Dr. Timothy Quill represents the respectable medical community's model of a physician's role in helping patients die good deaths. Quill's advocacy of PAS comes within the context of, first, providing highly effective palliative care for dying patients, and second, considering the possibility of PAS only when the standard of care has failed and patients continue in unremitting suffering. In seeking to overturn the State of New York's ban against PAS, Quill was involved in several state court cases, which eventually led to the 1997 U.S. Supreme Court landmark decisions (*Washington v. Glucksberg* and *Vacco v. Quill*) supporting a state's right to ban PAS. Some states currently ban PAS, few states have no PAS legislation, and only the State of Oregon has legalized PAS by referendum in 1994. Amid much controversy over its initial decision, Oregon legalized PAS again in a second referendum in 1997 shortly after the U.S. Supreme Court decisions.

Practices in the Netherlands of withholding and withdrawing treatment are similar to those in the United States, but the Netherlands also permits voluntarily requested death and physician-assisted suicide. German practices prohibit any role for the physician in directly causing death given the historical legacy of Nazi euthanasia programs, but, as in other countries, withholding and withdrawing of care are widely used to avoid unwanted or inappropriate prolonging of dying patients' lives. As German physicians are also prohibited from assisting patients' deaths, such assistance is publicly sponsored by various right-to-die organizations. The qualitative arguments conclude that the problem of euthanasia is one about the choice and limits of cultures (or models of dying) and the openness to change and adaptation of various cultural practices. In seeking resolutions to the problem of euthanasia, then, the overriding need is to ensure that political debate and empirical research are continuing and productive, historically and culturally informed, and that this issue becomes more than simply an opportunity to reiterate ideological and personal differences.

Lorraine Y. Landry

See also Assisted Suicide; End-of-Life Decision Making; Good Death; Medicalization of Death and Dying; Right-to-Die Movement

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EXHUMATION

Exhumation refers to the removal of human remains from their place of interment. In modern society exhumation occurs for a number of reasons, including repatriation to a different country, to change the type of disposal from inhumation to cremation, to change the location of interment, or to conform to a legal request. These types of exhumation are uncommon, particularly the latter, and are often difficult as many countries have laws

governing the disturbance of the dead. The majority of individual exhumations occur because the wishes of the deceased have been identified after inhumation has taken place. The other type of exhumation, both archaeological and forensic excavation, takes place to make way for new developments or to investigate the events surrounding ancient burial custom or modern crimes and genocides.

Exhumation in History: Politics and Grave Robbing

In historic cases, exhumation may have been facilitated by similar agendas, and examples of political and personal motivations exist where exhumation has been used to investigate, steal from, or punish the dead. Exhumation is also witnessed historically; Oliver Cromwell's body, for example, was exhumed after the reinstatement of royalty in England to facilitate his posthumous execution (Cromwell was Lord Protector of England 1653–1658 and commander of the parliamentarian forces in the civil war). Grave robbing can also be a form of exhumation, as many ancient civilizations placed valuable goods within their graves. During the New Kingdom, the ancient Egyptian ruling elite mutilated their tomb builders to prevent the location of their burial being revealed. Despite such measures and the use of protective traps and curses, many of these tombs were robbed in antiquity. This ancient tomb robbing targeted the valuable materials, but mummies were also destroyed or defaced, particularly those of controversial political figures like Akhenaten who, like Cromwell, was punished for his radical politics posthumously.

Grave robbing to acquire valuable material is a common theme in the literature of past societies, both in favor of the heroic act and warning against it because of magical or mystical defenses. This is seen in the story surrounding the death of the king Beowulf (in the 9th-century epic poem of the same name), in which a clumsy member of his retinue awakens a sleeping dragon during his ill-advised robbery of the tomb in which it slept. The dragon is subsequently slain by Beowulf, but Beowulf, by then an old man, dies in the battle. This type of event is seen in modern mythology, and the tale of Beowulf is mirrored in J. R. R. Tolkien's classic *The Hobbit* and subsequently built upon in his trilogy *Lord of the Rings*, in which spiritual guardians, both good and evil, live in ancient tumuli.

Medieval Exhumation

In medieval Europe exhumation of wealthy individuals is well documented. Foreign wars and martial punishment often meant that people were buried quickly or away from home, and it is not unknown for the surviving family of warring or crusading knights to travel with the sole intention of exhuming bodies, or parts of bodies, and returning them to the spiritual safety of family tombs, chapels, or burial grounds, so their remains could be prayed for. The same is true of religious and political figures, especially when individuals attained sainthood and their remains became religious relics and sites of pilgrimage. Two such examples were the remains of the Venerable Bede and Thomas Becket. The body of the scholar Bede was exhumed and reinterred in Durham Cathedral around 50 years after his death in 735 C.E., after it was claimed miracles took place at his tomb. Thomas Becket was exhumed twice after his burial. He was archbishop of Canterbury, and his assassination in 1170 C.E. resulted from a long running feud with Henry II over the rights and privileges of the church. He had been a popular and successful clergyman, and his resting place became the most popular site of pilgrimage in England. In 1220 C.E., over 40 years after his canonization, Becket's remains were exhumed and reinterred within a newly constructed shrine only to be reexhumed and destroyed by the agents of Henry the VIII during the dissolution of the monasteries in the 16th century.

The Body Snatchers and the Birth of the Horror Genre

In more recent history, exhumation took on a more sinister role. In the early 19th century, rogue surgeons and resurrectionists (the illegal agents of medical schools, particularly the school in Edinburgh, Scotland) exhumed the very recently dead to allow medical students and doctors to dissect them and learn human anatomy. The need for cadavers was so acute that the agents of Edinburgh extended up to 200 miles, as far south as Sheffield,

Yorkshire. The activities of these few men and women created a widespread cultural reaction, and guard towers were constructed, night patrols mounted, and patent coffins and brick-lined grave shafts were designed to prevent the theft of a loved one's body. The movement was so well documented that Burke and Hare, two resurrectionists who took the practice further by murdering victims, have been immortalized in popular films. Similarly, Mary Shelley's *Frankenstein* is thought to have been partially influenced by Mary's experiences at her mother's tomb in Old St. Pancras churchyard, a notorious haunt for the London resurrectionists. Her mother, Mary Wollstonecraft, was exhumed and moved to Bournemouth to be buried with her daughter.

Frankenstein is regarded as being the first work of horror, and the influence of resurrectionists or body snatchers can be seen throughout this genre. Exhumation was not limited to Britain but was practiced also in 19th-century America, Canada, and France, particularly Paris, for much the same reasons, although it does not seem to have been as well organized or orchestrated as it was in Britain.

Modern Exhumation: Archaeological Excavation and Forensic Investigation

In many European countries, exhumation takes place after a set period of time to move the remains to an ossuary and allow the burial space to be reused. This strategy is the direct result of the increasing need for burial space in heavily populated areas and is a contemporary cemetery management strategy. Other societies utilized disposal rites involving double burial, in which a body is exhumed and reburied in a second funeral rite. Examples of these societies include rural Greek Orthodox communities. Not all contemporary exhumation is cultural or even legal; though rare, bodysnatching continues, sometimes with political motivations. In 2004, the remains of Gladys Hammond, a farmworker's mother-in-law, were stolen from a churchyard by animal rights campaigners protesting the guinea pig–breeding program on the farm.

Mass Exhumation

Mass exhumation may also take place as a result of the pressures to develop historic burial grounds in urban areas such as London, England. Recent exhumation projects include the King's Cross Eurostar platform that extended the train terminus directly into the cemetery of Old St. Pancras Church. Clearance at this site had taken place historically, and in the late 19th century the writer Thomas Hardy, while an architecture student, was responsible for supervising the exhumation of the cemetery for the insertion of the underground tunnel and structural support for the overland railway line. This experience had a profound effect on Hardy, and it was during this time he wrote the poem "Neutral Tones," reflecting his persistent problem relating to women. Hardy's later poems "The Levelled Churchyard" and "Ah, Are You Digging on My Grave" seem to be directly influenced by his experience at St. Pancras. Today this type of work may be conducted within crypts or cemeteries; it is occasionally carried out by undertakers but most commonly by specialist exhumation companies, archaeologists, or both. However, the experience of being involved in mass exhumation is difficult, and many modern archaeologists working in recent or historic burial grounds complain of bad dreams or poor sleep.

Excavation

When conducted on ancient or medieval cemeteries by professional archaeologists, exhumation is referred to as excavation. This scientific process is designed to get the most cultural data on an ancient society as possible and will include the three-dimensional recording of individuals' bodies, the context within which they were situated, and the identification and preservation of grave-goods. Trained physical anthropologists are often used to ascertain the age at death, sex, health, and diet of the individuals from their skeletal remains. This practice is, like exhumation, often conducted in preparation for commercial development and occasionally by university teams for research.

However, there are social and cultural taboos surrounding the exhumation or excavation of the dead, and in many societies it is viewed very negatively. Indeed, in New World countries, particularly in North America and Australia, the different views of archaeologists, construction companies, and indigenous groups have resulted in conflict that is often based on different attitudes to the past and

views as to what is of most cultural value: excavation or preservation. This conflict seems to be influenced by the nature of the postcolonial relationship between indigenous and nonindigenous populations. In the United States, for example, the arguments surrounding access to ancient cemeteries and the repatriation of the dead center on the differential treatment of Native American and colonial Caucasian remains. Many agree that the debate has political undercurrents and has provided an opportunity for the Native American population to regain control over their cultural heritage.

In Old World countries, the debate is often related to religion or religious organizations: The Jewish community objects to the disturbance of the dead, whereas for Protestant, Catholic, and nonconformist churches, the questions of access surround the context of the development, the individual community, and the age of the cemetery. Recently, English neopagan groups have also started to express a vested interest in prehistoric human remains, although it is difficult to separate their claims from the rest of British culture of which they are a part.

Forensic Exhumation

Forensic exhumation is the process of investigating mass graves of the recent dead, although it has also been used to describe the archaeological investigation of battlefields and war graves. This is usually used to explain investigations of the victims of massacres, war crimes, or genocide and is particularly applicable to the legal investigations that followed the Guatemala civil war (1960–1996), the Rwandan genocide (1994), and the Kosovo war (1996–1999) and the investigation of the crimes of the Iraqi dictatorship (1968–2006). The methods of forensic investigation are derived from those used in archaeology, which involve site identification using air photographs, ground-based prospection (radar, resistance metering, magnetic sustainability), and excavation. Such activities are intended to assist in identification of the victims of mass murder and the causes of death as well as the events that lead up to it. The aim of this type of investigation is to scientifically document massacre sites and events and is often used to assist in the prosecution of those involved. The methods and skill used in archaeology and forensic archaeology have a wide application; for example, physical anthropologists and archaeologists assisted in the recovery and identification of the victims uncovered during the cleanup of the World Trade Center site in New York.

In summary, exhumation is the act of removing a body from its grave. Some societies practice double funeral rites, but in the West, exhumation is conducted for personal, political, or educational motivations. In the medieval period, pilgrimage to tombs could ensure exhumation of relics, and in the 19th century, fear of exhumation resulted in changes, not just to coffins but also to cemetery organization. Indeed exhumation helped to inspire the birth of a new literary genre and continues to influence it today.

In the modern West, exhumation has been conducted as part of educational investigation and archaeology, and it contributes to the study of human history and the human experience. Archaeology has contributed to the use of exhumation as a legal investigation, but it is not without controversy, especially in the New World, where to indigenous populations, scholars of physical anthropology have been regarded with suspicion and hatred, similar to how the 19th-century resurrectionists were regarded.

Duncan Sayer

See also Body Disposition; Burial Laws; Cremation; Curses and Hexes; Forensic Anthropology; Grave Robbing

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Familicide

Taking of the life of a family member—including the killing of intimate partners or spouses, parents killing children, sibling killings, and children killing their parents—is known as familicide. Some researchers define the concept familicide as the killing of an intimate partner but only if the act is accompanied by the killing of at least one child. Such events represent one form of mass killing, an event that often ends with the suicide of the offender. Familial homicide is best understood within the context of domestic violence, of which most killings are committed by the male partner. And while the female homicide offending rate is low, when women do engage in familicide it is usually in response to being a victim of physical abuse.

Familicide Statistics

Since the mid-1970s, federal statistics show that family homicide rates or the number of homicides per 100,000 population in the United States have declined, primarily due to the decreasing incidence of intimate partner homicides. The majority of familicides are committed by male adults, and most of the victims are intimate female partners or spouses. Because federal statistics report the number of homicides by individual victim and offender characteristics, most homicide data involve a comparison of one offender with one victim. Understanding familicide as a mass killing of family members entails using both anecdotal reports from media accounts and the national data. In analyzing such data, it is estimated that approximately one half of all mass homicides committed in the 20th century are related to familicide.

The incidence of family homicide declined during the period from 1976 to 2005. In 1976 intimate killings (killings by partners or spouses) numbered 2,246; by 2005 the number decreased to 810. Children comprise the next largest number of family homicide victims; in 1976 parents killed 551 children and, in 2005 parents killed 470 children. Sibling homicides represent the lowest incidence with 136 killings in 2005, while parental deaths accounted for 271 killings at the hands of their children during that same year.

Demographic Characteristics of Family Killings

In the United States, the majority of offenders and victims are young males, and black victims and offenders are disproportionately represented in national statistics. However, the general pattern of familial homicide trends is similar for both blacks and whites. For other racial and ethnic groups federal reports combine victimization–offending characteristics because these numbers are less than 1% of family homicide annually. However, family violence and family homicide crosses all socioeconomic categories and affects families of all races and ethnicities.

Almost one half of the victims and an equal portion of the offenders were between the ages of

18 and 34 years of age, with 47% and 46%, respectively. Spousal/partner killings are the most common familicides; the next most common are killings of children by their parents. When a child kills a parent, it is most likely a teenage son who kills his father. Teenage or young adult brothers are most often involved in the killing of a sibling; it is extremely rare that a daughter or sister kills either a parent or sibling. Understanding the nature of such information requires some understanding of the dynamic nature of domestic family violence.

Intimate Killing: Women Battering and the Cycle Theory of Violence

Intimate violence is largely unreported in the United States, but for those instances that do receive recognition, the longer a family violence victim stays in the relationship, the greater is the likelihood that she will die a violent death. Although persons of either gender can be a victim of domestic violence, most victims are female. According to the cycle theory of violence, the battering cycle has three phases: tension building, explosion, and loving contrition. First, a batterer is unable to handle life stress and day-to-day problems; as tension builds, the batterer will engage in verbal condescension with the partner. Second, when the tension is too great, the batterer will use physical aggression and violence to release his or her anger. Third, immediately following the explosion, the batterer feels remorse and promises never to hit the victim again. Over time, the cycle will repeat itself with the level and intensity of the violence increasing each time.

Reasons Victims of Family Violence Stay

Victims of family violence tend to believe that the batterer will change and mistakenly think they can change the batterer's behavior. The victim tends to believe she is responsible for the batterer's aggressive behavior; children also believe it is their mother's fault, in turn blaming her for the family problems. As the degree of physical violence increases, victims begin to realize the battering will not end. The batterer is extremely likely to threaten to kill the victim, their children, their pets, and himself if the victim leaves or attempts to leave. At this point, the victim of domestic violence may feel "helpless." Such learned helplessness is the state in which victims of family violence realize that they cannot hide from the batterer. If the victim leaves and is later found by the offender, severe battering results. The victim "learns" to take the abuse. Many victims are isolated from other family members, neighbors, and others who might otherwise assist the victim.

Repeated Family Violence and Homicide

Studies of male homicide offenders conducted during the 1980s and 1990s show that the police were called to homes for family violence numerous times prior to the homicide incident. Often the offender is on probation when the partner is killed. Many partner homicides are committed with the use of a weapon such as a gun, but strangulation is another common method.

Violent episodes seem to be akin to the episodes in which death did not occur. That is, the killing of family members occurs as a part of the battering explosion as opposed to representing a distinct phenomenon. When batterers kill their partner, children, and themselves during the same event, the act of suicide is thought to represent a means by which one escapes being held accountable. This may be a manifestation of one who controls the family outcome as well as his own fate.

Characteristics of Lethal Families

Based on research findings reported during the past several decades, new state and federal criminal justice policies and laws were created to reflect this new knowledge. Psychometric tools also are employed for the purpose of identifying batterers and to respond to victim and family needs. Among the factors that can denote the potential for violence are a prior history of violence, the batterer's jealous or obsessive controlling behavior, prior police visits to the home, prior threats to kill the victim, issuance of an order of protection, threats posed by the victim that she will leave the batterer, use of alcohol or drugs, and threats to commit suicide.

Most offenders are not mentally ill and exhibit normal behavior in the workplace or outside of the home. But it is suggested that one major difference between batterers who kill and those who do not kill may be the availability of, and access to, firearms. For this reason a number of states

prohibit the possession of firearms when a protective court order is in force.

When women kill their partners, it is usually in reaction to a long history of abuse by their partner. But in those states that currently have enacted laws specifically prohibiting domestic violence and also have support systems in place to assist women and children in need, the numbers of partner homicides committed by females have decreased.

Conclusion

Although the prediction of familicide is at best uncertain, the characteristics of women victims killed by a partner are similar to those of other battered women. Agencies usually treat domestic violence cases on a one-to-one basis, although this practice is now under review. Domestic violence laws now reflect the recognition of the great potential for a lethal outcome. Criminal justice agencies in major cities are creating specialized task forces and departments to better respond to the needs of domestic violence victims. In police agencies, domestic violence units handle investigations for severe instances of abuse and work closely with shelters and domestic violence groups. In some cities, there are now domestic violence courts in which a judge handles cases and is able to track repeated violations of orders of protection in order to provide consistent oversight of violators. These practices have been deemed to be successful by victims, practitioners, and agency service providers.

Frances P. Bernat

See also Domestic Violence; Manslaughter

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Famine

Famine is an economic and social phenomenon resulting from regional failures of food production or distribution systems and leading to sharply increased mortality. It is evidenced by body weight loss, emaciation, and the weakened condition of the population. Famine can be caused by natural disasters, such as drought or flood; in the modern world, war is its most frequent origin. Death occurs when about one third of the healthy body weight has been lost. The young, small, and highly active die first, and young children who do manage to survive famine often are brain-damaged. Acute starvation also causes depletion of the lymphoid system, so the body cannot produce antibodies and therefore cannot fend off disease. Epidemic diseases found in famine zones include cholera, typhus, typhoid fever, and dysentery. The lack of clean water and medicine exacerbates the situation. In recent times, dictatorships that appear able to afford sophisticated weapons systems and armaments have used famine as a further weapon against their own people. Through examination of a number of historical famines, this entry shows that incidences of starvation are allowed to become famines because of a lack of political will to prevent them.

Physiological and Social Descriptors

Invariably, famine implies starvation, whereas it is not the case that starvation implies famine. Starvation exists where people do not have enough to eat; it does not necessarily mean that there is not enough food available. As people begin to starve, their food requirements decrease because their metabolic rates slow down, and it becomes more

difficult for them to undertake ordinary tasks. In any country that operates a harvest economy, three consecutive bad harvests create famine conditions. It is always a temptation for starving people to eat the following year's seed supply, which fends off immediate starvation but leads to greater problems the following year. Often, the men take food first, and women and children go hungry. Females are able to withstand starvation to much lower body mass indices than are males because females have a greater amount of fat-storing tissue and they use up fat rather than muscle tissue, enabling them to survive.

Although famines appear to be catastrophic events, there are usually signs of impending disaster long before the event itself. Famines are rarely caused by a single factor, either human or natural in origin. Moreover, it is difficult to distinguish between famine and starvation. If food is available in a region, then the incidence of what is known as famine is, in reality, starvation.

The physiological manifestation of starvation may be divided into two main types: marasmus and kwashiorkor. Marasmus is a severe form of malnutrition caused by inadequate intake of protein and calories and usually occurs in the first year of life. The effects on the body are physical wasting and a loss of subcutaneous fat and muscle, resulting in growth retardation. Children who suffer from marasmus display decreased activity, lethargy, apathy, slowed growth, and weight loss. Kwashiorkor is one of the more severe forms of protein malnutrition. Symptoms include weight loss, stunted growth, generalized edema, abdominal swelling, diarrhea, and decreased muscle mass. Both of these forms of starvation are seen during incidences of famine.

To fend off the pains of hunger, starving people often resort to eating tree bark, grass, clay, and other indigestible matter which fills the belly but has little or no nutritional value. The ingested fiber often contains phytates, which reduce the absorption of iron and other minerals from such foods as are available. People who traditionally eat predominantly carbohydrate diets such as potatoes, rice, plantains, and yams find it harder to get the necessary energy requirements and proteins from these foods. Consequently they are often undernourished even in times of good food supply.

History

There are many different causes of famine. Historically famine has been the result of natural disasters: Floods wash away crops; droughts prevent crop growth; volcanic eruptions and earthquakes cause severe disruption; or diseases (such as the fungus *Phytophthora infestans,* which caused the European potato blight in the 1840s) cause crop failures. However in modern times, various human activities have caused most famines. The effects of soil erosion from overcultivation and overgrazing, the destruction of rain forests, and the increase of urban sprawl cause desertification, leading to famine. Overpopulation has also resulted in famine, particularly in third world countries where religious and cultural norms often demand large families. Since 1930, wars or revolutions have led to the destruction of homes and crops, the displacement of populations, and starvation. Political decisions, such as collectivization in the Ukraine in 1932–1933 and China's Great Leap Forward of 1956–1961, have also caused famine.

Ancient Civilizations

The earliest recorded famine occurred in Egypt in about 3500 B.C.E.; another famine in 2180 B.C.E. was caused by a rise in temperatures which, among other things, led to low flood levels on the River Nile. Because Egypt's existence was dependent on the Nile floods, any disturbance to the annual inundation invariably had adverse effects on the Egyptian people. Another Egyptian famine began in 1708 B.C.E. and lasted for 7 years. It is possible that this famine is documented in the biblical story of Joseph, who interpreted Pharaoh's dream warning of 7 years of plenty followed by 7 years of famine.

A famine in Rome in 436 B.C.E. caused thousands of people to throw themselves into the River Tiber rather than await death from starvation. In later Roman history, grain was seen as a form of wealth, which the emperors preferred to hoard rather than provide as food to the starving. Sometimes the Romans were either unwilling or unable to transport vast quantities of grain to needy parts of the empire. Latterly the Roman emperors systematically used the supply or withdrawal of grain as a means of controlling the population. Public order was maintained by

providing "bread and circuses." Between 400 and 800 C.E. the population of Rome fell by over 90%, mainly through famine and plague, brought about by the barbarian invasions.

The Medieval and Early Modern World

Severe droughts hit Central America between 800 and 1000 C.E. These precipitated the collapse of the Mayan civilization, which was unable to function with a reduced population. Those who survived continued as peasant farmers but the glories of the Maya fell into decline. In war-torn, harvest-economy, medieval England there were at least 95 famines, the worst being in 1235 when, in London alone, 20,000 people died. Famine and pestilence laid waste to China between 1333 and 1337. Drought was followed by excessive rains, which caused destructive flooding. A series of natural disasters, plagues of locusts, and the inability of the government to provide aid resulted in the deaths of 4 million people in the lower reaches of the Yangtze River. Famines in China in 1810, 1811, 1846, and 1849 claimed another 45 million lives. The black death, which swept across Europe between 1347 and 1351, is estimated to have killed half the total population, causing the collapse of the agrarian-based society. Survivors were subjected to famine conditions because crops had been neither harvested nor planted during the crisis years.

Later famines were caused by natural disasters. Between 1648 and 1660 Poland lost about a third of its population from war, plague, and accompanying famine. The Scottish famine of the 1690s killed about 15% of its population. In India, the Deccan famine of 1702–1704 saw the deaths of 2 million people, but the first of the Indian famines to attract widespread interest in the Western world was that of 1769–1770. It is estimated that 15 million people—a third of the Bengali population—died. The famine was caused by the failure of the rains, exacerbated by poor administration on the part of the East India Company. In 1783 the Laki volcanic eruption in Iceland resulted in abysmal harvests, leading to a famine that killed about a fifth of the people.

Russia

The Russian people often were ruled by dictators, be they czars or the Communist Party. Famine has also been endemic. Between 971 and 1971 Russia experienced 121 famine years and another 100 hunger years: That is, there was, on average, one hunger/famine year every 5 years. Between 1600 and 1799 this fell to one hunger/famine year in every 3 years. These dates coincide with the little ice-age in the northern hemisphere, when temperatures fell and crops were difficult to grow. The worst period was 1601–1603 when as many as 10,000 in Moscow and a third of the total population died. The same famine wiped out a third of Estonia's population. When hunger is endemic and people live hand-to-mouth, it takes very little to change difficult conditions into disaster. More recently, the great Ukrainian famine of 1932–1933 was the result of Stalin's political will. It was used as a tool to end the newly emerging Ukrainian cultural renaissance and the local resistance to both collectivization and Communism. The Ukraine is famous for its fertile black earth and the volume of grain that can be grown. In 1932 Stalin increased the demand for grain supplies by 44%. He knew that this huge quota would cause such huge grain shortages that the peasants would be unable to feed themselves, but the law was clear: No grain would be provided locally until the peasants had met the quota. Party officials ensured that no grain was hidden and then issued internal passports, preventing Ukrainian peasants from moving elsewhere to find food. Not only grain was taken but also potatoes and beets. It is estimated that between 5 and 8 million Ukrainian peasants starved to death.

Ireland

The potato famine that affected Ireland between 1845 and 1849 led to a 30% fall in the population, caused by the deaths of some 1½ million people and the emigration of a similar number, mostly to America. The fungus *Phytophthora infestans* had spread across Europe before arriving in Ireland. In the peaty, infertile west of Ireland especially, the peasants were almost solely dependent on one potato species: the lumper. In 1845 the fungus wiped out the entire potato crop, precipitating a series of events that led to disaster as it was impossible to eliminate the fungus. The potato harvest failed for 5 consecutive years, destroying the crop that provided about 60% of the nation's food needs.

Technically, the potato famine was not a famine but rather a starvation, since food was available in Ireland and continued to be exported while the peasants starved to death. However, the food gap created by the blight was so huge that it could not have been filled even if all the exported food had been kept in Ireland. By the late 1840s, more food was being imported than was exported and still people starved because they could not afford to pay for it. The United Kingdom's free trade policy prevented the free distribution of food, so public works were established where men were given tasks such as building roads and harbors, filling valleys, and leveling hills to earn money to buy food. However, starving men simply did not have the energy to undertake heavy manual labor, and their efforts to do so increased their metabolic rates, speeding up the rate of starvation.

The price of food in Ireland increased rapidly because grain merchants hoarded it. This put food out of the financial reach of the vast majority of the population. The workhouses could not cope with the influx of paupers, and roads were littered with the corpses of those who had died from typhus and typhoid fever. Independent organizations, particularly the Quakers, set up soup kitchens that alleviated starvation in some areas, but the far west of Ireland was inaccessible and there the people starved. Some landlords, many of whom were Irish, took the opportunity to evict their tenants to undertake land improvement, causing further suffering for those who were starving.

Bengal

The Bengal famine of 1943 resulted in the deaths of about 4 million people. This phenomenon was caused, in part, by high inflation in a war economy and also by rising public spending on military and civil construction. There had been a poor harvest in 1942 following a cyclone, torrential rain, and fungal disease. Japan occupied neighboring Burma and cut off rice exports to Bengal. These factors led to famine conditions followed by high incidences of malaria, cholera, and smallpox. The colonial government prohibited food exports from other, well-provided provinces. This caused another rise in food prices in Bengal, which meant that people could not afford to buy nonessential goods. There was a consequent loss of income for people such as fishermen, landless laborers, and paddy huskers who also found that the real value of their wages had fallen by two thirds since 1940. The situation did not ease until after the end of the war.

China

Between spring 1959 and the end of 1961, approximately 30 million Chinese peasants starved to death, with a similar number of lost births in the worst famine of the 20th century. As in Russia, this famine had ideological origins. Drought was a contributory factor in a country where inadequate water supply is common, but the greatest responsibility has to be borne by Mao Zedong, who launched the Great Leap Forward in an effort to produce vast amounts of steel. The peasants were forced to abandon the land in the frenzy to meet unrealistic demands for steel, which actually turned out to be useless. Concurrently the leaders of the collective farms produced fabricated reports of record harvests. The Party expropriated vast amounts of grain to feed the growing urban populations and to export in order to fund China's nuclear aspirations. In actuality, the grain harvest had collapsed, and the peasants were left with nothing to eat once the government demand for grain had been met. Before 1958 there was sufficient food to feed China's entire population, but by the spring of 1959 there was famine in the rural breadbasket of the country that continued for 3 years. Despite knowing this, Mao did nothing to alleviate the distress of his people.

Africa

In Africa's recent past, most famines have been caused by political upheavals and civil wars. The Biafran war of 1967–1970 was a political conflict caused by the attempted secession of Nigeria's southeastern provinces to create the Republic of Biafra. Nigerian forces surrounded the breakaway area, cutting off supplies. This led to a widespread humanitarian disaster in the besieged areas. It was claimed that to win the war, the Nigerian government used famine as a means of genocide. In Sudan in 1998, famine was a political, military, and economic weapon used by the government and its allies to take control of the oil-rich lands of the

south. To the north of Nigeria is Niger. Conditions there in 2005 initially were no different from other disaster areas in Africa where warning signs are commonplace. Late in the main rainy season of 2004, a plague of locusts invaded the agricultural lands of Niger, causing localized damage. Soon afterward the rains halted abruptly, causing the harvest to fail. Cereal prices started to rise, and although food was plentiful the people could not afford to buy it; these conditions led to a food crisis, malnutrition, and disease, followed by regional famine. The worst incidences of famine came from the relatively wealthier parts of the country: These areas were more densely populated by poor wage-laborers working on cash-crop farms who could not afford to buy food.

Ethiopia has suffered from famines throughout its history. Traditionally, the people live in a subsistence economy in which any surplus food has been taken by the ruling elite. The peasants therefore lack any incentive to improve their agricultural practices. Failure of the rains, plagues of locusts, cattle murrain, and almost constant warfare have caused persistent famines in the country.

Between 1888 and 1892 about a third of the Ethiopian population died, and 90% of cattle died from rinderpest, which was introduced from India. Drought then led to famine conditions everywhere except the southern provinces, which then were attacked by locusts and a caterpillar infestation, destroying the crops. Conditions worsened when cholera broke out; cholera was followed by typhus and smallpox epidemics.

Ethiopia is a poverty-stricken nation where the peasants farm land in unsustainable ways, causing soil degradation. Frequent wars also militate against crop production as soldiers steal any available food. Drought wiped out the 1981 harvest and in subsequent years the spring rains failed and disease destroyed crops. In March 1984 the Ethiopian government said that 5 million people were at risk of starvation because the country could not provide sufficient grain. Meanwhile, the ruling dictatorship spent 60% of the national income on warfare, buying state-of-the-art weaponry to wage civil war against the provinces of Eritrea and Tigre. Foreign governments were reluctant to send aid to a country whose own government was doing nothing to help and which was diverting food aid to feed its troops. Later that year reporter Michael Buerk of the BBC (British Broadcasting Corporation) brought the West's attention to the unfolding Ethiopian disaster. Public donations amounting to £100 million were raised in a few months. Bob Geldoff organized two Live Aid concerts and produced a record that also raised millions of pounds worldwide. Despite every effort, drought and famine are still recurrent problems in Ethiopia, the civil war continues, and the people are poorer now than in 1984.

Conclusion

In November 2001, the UN Food and Agriculture Organization estimated that there were some 815 million chronically malnourished people in the world. More than 30 countries encompassing over 50 million people were facing severe food emergencies. Famines necessarily affect the poorest and least articulate in society, those who have little or no political impact on governments. The modern world is more than capable of producing enough food to sustain its current population of almost 7 billion souls. If the warning signs of famine could be detected earlier (the major cause of food insecurity is war) and if governments and aid organizations could act in concert, without the debilitating effect of corruption, we could eradicate famine.

Marjie Bloy

See also Atrocities; Disasters, Man-Made; Disasters, Natural; Epidemics and Plagues; Genocide

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Fatwa

A *fatwa* is a nonbinding legal opinion within the Islamic legal tradition. The issuance of such legal opinions has its origins in the earliest Islamic period, as jurists among the Companions of the Prophet issued various fatwa to address numerous concerns following the death of the Prophet Muhammad. Fatwa are considered nonbinding because another scholar may come to a different conclusion about a subject, as there is often more than one possible interpretation of the source text.

The terms for independent reasoning (*ijtihad*) and juristic opinion (*fatwa*) are often used interchangeably; however, the critical difference between the two terms is that *ijtihad* has a greater degree of juridical substance and often requires an explanation of its reasoning and evidential basis, whereas a *fatwa* most often consists of a verdict or opinion that is given in response to a particular question. It is not necessary for a fatwa to provide an explanation of its evidential basis; thus, the text of a fatwa may either be very brief or include greater depth and detail.

Fatwa are often sought by individuals who need legal advice in the context of litigation. In such cases, the fatwa may be cursory and brief. When a fatwa addresses complex issues the jurists often feel the need to probe into the course evidence, in which case his finding may be equivalent to ijtihad. Neither the result of ijtihad nor the finding of a fatwa binds the person to whom it is addressed, unless it is issued by a formally constituted court, in which case the decision would carry a binding force.

Ijtihad may only be carried out by a highly qualified legal scholar (*mujtahid*), whereas a fatwa may be issued by a mujtahid or by a scholar of lesser knowledge, though basis in Hadith and narrators of traditions, of the hermeneutics of the Qur'an (*tafsir*), and of the customs and conditions of society must be taken into consideration by anyone issuing a fatwa. For instance, Fatwa issued by prominent scholars and jurists, include Rashid Rida, Abu Zahra (d. 1974), Mahmud Shalut (d. 1970), and the contemporary jurist of the al-Jazeera television network, Yusuf al-Qaradawi. In some cases, fatwa are issued by larger groups such as nongovernmental organizations. In the 1970s, Pakistan gave the process of collective issuance of fatwa a state mandate by forming the Islamic Ideology Council at the government's initiative. Malaysia's National Fatwa Council is a similar statutory body. The various states of Malaysia also maintain fatwa committees that aid the Muftis of each state in their deliberations.

Pragmatism

The creation of large fatwa councils and self-contained Islamic universities also aided the development of new methods of teaching and scholarship in relation to legal opinions and reflect the pragmatism of defining Islamic law. Interpretations of Islamic law have frequently made concessions to the sick, the elderly, pregnant women, and travelers, as well as others who face hardship regarding daily prayers and fasting. It also makes provisions for emergencies, in which the rules of Shari'a may be temporarily suspended on grounds of necessity. Thus, the fatwa of a mujtahid must take into consideration changes of time and circumstance. For instance, people were not allowed in the early days of Islam to charge a fee for teaching the Qur'an, as this was an act of spiritual merit. Later, it was noted that people no longer volunteered to teach, and knowledge of the Qur'an declined. The jurists consequently issued a verdict that reversed the former position and allowed payment of remuneration for the teaching of Qur'an. Note also the pragmatic verdict of Imam Malik of the 10th century, which permitted the pledging of allegiance (*bay'a*) for the lesser qualified of two candidates for leadership, if this is deemed to be in the public interest.

The same logic can be applied to the uprightness of a witness. In more modern times, national fatwa councils introduced research-oriented scholarship to take into consideration not only the traditional subjects, but also new areas such as the Islamic law of obligations, Islamic constitutional law (*al-fiqh al-dusturi*), Islamic economics, Islamic banking and finance, and human rights studies. In a more recent development the introduction of fatwa councils in major banks and financial institutions, which are charged with the task of ensuring compliance with the Shari'a in banking operations, has become commonplace.

Enforcement

Despite the flexibility of interpretation within Islamic legal opinions and the nonbinding nature of a fatwa, there are required source texts that each fatwa ought to address. The source text for a fatwa are first the Qur'an, as it is the highest authority, and then the Sunna. If an issue is not clearly addressed in the Qur'an or the Sunna, the jurist then looks to see if there is any consensus among the scholars concerning the matter. If no clear proof is found in any of these three sources, then the jurist exerts all intellectual and spiritual efforts to arrive at a sound position that is consistent with the goals of the Sacred Law, through analogy or one of several other legal considerations. These considerations include analogical reasoning based on existing texts, equity, public good, permissibility, and precedents.

Moral Versus Legal Obligations

The distinction between moral and judicial obligations also characterizes the difference between adjudication (*qada*) and fatwa. The judge (*qadi*) must decide his cases based on apparent evidence, whereas a jurisconsult (*mufti*) investigates both the apparent and the actual positions. Both are reflected in the verdict. In the event of a conflict between the two positions, the mufti can base his fatwa on religious considerations, whereas the judge must consider objective evidence only. Hence, a pious individual in a court case is not treated differently from a person of questionable piety or of no apparent religion.

This distinction has allowed for a changing nature of the fatwa. The Islamic jurist Shafi'i (767–820 C.E.) maintained that a mujtahid should not hesitate to change a previous ruling (fatwa) if this would make a better contribution to the quest for truth. Thus, Shafi'i frequently changed his own verdicts and sometimes recorded different rulings on the same issue. For example, if a man deceives a woman he marries by claiming a false family pedigree, he is liable to punishment. Shafi'i had two separate views on this subject, but neither is given preference over the other. The first view entitles the wife to choose to either continue the marriage or separate. The second view rules that the marriage is void. Shi'ite jurists have adopted Shafi'i's views and recognize that in the absence of the Hidden Imam, the contemporary jurisprudence, which serves to as a stand-in for the Imam, can, in fact, override the fatwa of his predecessors.

Michael Bracy

See also Death Superstitions; Muslim Beliefs and Traditions

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Fear of Death

See Death Anxiety; Humor and Fear of Death

Food Poisoning and Contamination

Food poisoning, which is also called food-borne disease and food-borne illness, is a term used to describe illness resulting from the consumption of contaminated food. This entry provides general information on food poisoning and contamination, including symptoms and a discussion of common food contaminants. Food poisoning is a common, sometimes mild and sometimes life-threatening problem for millions of people around the world every year. Although there may be no symptoms in some cases, symptoms may range from mild intestinal discomfort or nausea to severe diarrhea or even dehydration. Depending on the type of contaminant, fever, chills, bloody stools, dehydration, nervous system damage, or even death may occur as a result of food poisoning. Cases where two or more people become ill as a result of consuming the same food are called outbreaks.

True food poisoning occurs as a result of ingesting a contaminating chemical or toxin, while most cases of food-borne illness are caused by food-borne bacteria, viruses, prions, or parasites that contaminate food. Food-borne illness generally results from poor sanitation or the improper handling, preparation, or storage of food. Following good hygiene practices before, during, and after food preparation can reduce the probability of contracting a food-borne illness. Food handlers who have infections or do not wash their hands after using the bathroom may cause contamination, and improperly packaging or storing food can also lead to contamination.

More than 250 different diseases can be transmitted through foods, most of which are infections caused by a variety of parasites, viruses, and bacteria that can be food-borne. According to a report by the Centers for Disease Prevention and Control (CDC), unknown or undiscovered agents cause 81% of food-borne illnesses and related hospitalizations. However, many cases of food poisoning are unreported because the symptoms are mild and victims may recover quickly. Also, doctors do not test for a cause in every suspected case of food poisoning because it would not change the treatment or outcome.

According to CDC estimates, food poisoning causes about 76 million illnesses, 325,000 hospitalizations, and up to 5,000 deaths each year in the United States. Visitors to developing countries often encounter food poisoning in the form of "Montezuma's revenge" or "traveler's diarrhea," and diarrheal illnesses are among the leading causes of death worldwide. In addition, there are new global threats regarding the contamination of the world's food supply through terrorist actions, using food toxins as weapons.

The types of food-borne diseases affecting humans constantly change over time. Common food-borne diseases a century ago, including typhoid fever, tuberculosis, and cholera, have been controlled as a result of improvements in food safety, such as the pasteurization of milk, proper canning, and disinfection of water supplies. Other food-borne infections have taken the place of these diseases of the past, and new food-borne infections continue to be discovered. These new diseases emerge because contaminating agents can easily spread around the world and evolve, the environment and ecology change, food production practices and consumption habits change, and better laboratory procedures make it possible to identify previously unrecognized agents.

The "acceptable daily intake" levels and tolerable concentrations of contaminants found in individual foods are determined by conducting animal experiments that provide a safety factor based on "no observed adverse effect level." The U.S. Food and Drug Administration (FDA) oversees the maximum concentrations of contaminants allowed in foods, with the maximum concentration often being well below toxicological tolerance levels. The amount of an agent that must be consumed to lead to symptoms of food-borne illness is the infectious dose, which varies based on the agent and the consumer's age and health.

Symptoms

The different harmful agents found in foods and water lead to many different symptoms, so there is no single set of symptoms for food-borne illness. Food-borne illness is typically evident when uncooked or unprepared food is consumed, and symptoms of food-borne illness generally occur within 48 hours after consuming a contaminated food or beverage. The delay between consuming a contaminated food and the appearance of symptoms, which ranges from hours to days or even months or years in rare cases, is called the incubation period. The incubation period depends on the agent and the amount consumed. Having symptoms that occur within 6 hours after consumption of a food indicates that the food-borne illness is caused by a bacterial toxin or chemical rather than live bacteria. During the incubation period, microbes pass through the stomach and into the intestine, attaching to the cells lining the intestinal walls and multiplying. Some agents stay in the intestine, some produce a toxin that is absorbed into the bloodstream, and others directly invade deeper body tissues. Symptoms are dependent on the type of agent consumed.

Depending on the agent involved, symptoms can include one or more of the following: nausea, abdominal pain, vomiting, diarrhea, gastroenteritis, fever, headache, or fatigue. The body is able to permanently recover after a short period of illness in most cases. Certain groups, including babies,

young children, pregnant women and their unborn children, the elderly, and those who are sick or have weak immune systems, are more likely to face permanent health problems or even death. Foodborne illness may also cause reactive arthritis, which generally occurs about 1 to 3 weeks afterward. Symptoms of Creutzfeldt-Jakob disease, which is usually transmitted by eating beef from cows with bovine spongiform encephalopathy (also called mad cow disease), differ from bacterial food poisoning and appear after many years. After symptoms appear, the disease is fatal.

Food Contamination

There are two categories of known food poisoning agents: infectious and toxic. Some of the most common infectious agents are those caused by bacteria, including botulism, *Campylobacter, Salmonella, Staphylococcus aureus, Shigella,* and *E. coli,* as well as a group of viruses called calicivirus, which are also called Norwalk and Norwalk-like viruses. Infectious agents also include parasites.

Botulism

Botulism is caused by *C. botulinum,* which is unlike any of the other food-borne bacteria in that it can only live in the absence of oxygen and includes neurotoxins that poison the nervous system and lead to paralysis without the vomiting and diarrhea associated with other food-borne illnesses. Botulism is much more likely than other infectious agents to be fatal, even in tiny quantities. Botulism outbreaks are generally associated with home-canned food, although commercially canned foods are occasionally responsible for the disease. Symptoms of adult botulism appear about 18 to 36 hours after the contaminated food is consumed and begin with the person suffering from weakness and dizziness with double vision. Symptoms progress to difficulty swallowing and speaking, with paralysis moving down the body. Those showing signs of botulism must receive immediate emergency medical care to increase the chances of survival.

Campylobacter Jejuni (C. jejuni)

The FDA reports that *C. jejuni* is the leading cause of bacterial diarrhea in the United States. Although anyone can get food poisoning from this agent, children under age 5 and young adults between the ages of 15 and 29 are more frequently infected. *C. jejuni* is carried by healthy cattle, chickens, birds, and flies and is also found in ponds and stream water. Symptoms of food poisoning from *C. jejuni* generally begin 2 to 5 days after eating contaminated food, with symptoms including fever, abdominal pain, nausea, headache, muscle pain, and diarrhea. Symptoms last from 7 to 10 days, and relapses occur in about one quarter of those infected.

Salmonella

Between 2 and 4 million cases of food poisoning from *Salmonella* are estimated to occur each year in the United States. *Salmonella* is found in raw and undercooked poultry and meat, dairy products, fish, shrimp, egg yolks from infected chickens, and other food products. The CDC estimates that 1 out of every 50 consumers is exposed to a contaminated egg yolk each year, but thoroughly cooking eggs kills the bacteria, leaving the food harmless.

Staphylococcus Aureus

Staphylococcus aureus is found in environmental dust, air, and sewage, as well as on the human body. It is mainly spread by food handlers following poor sanitary practices. Foods kept at room temperature are more likely to be contaminated. Symptoms of *Staphylococcus aureus* are similar to those caused by other food-borne bacteria, with many cases being very mild and not requiring physician care. Symptoms generally appear within 6 hours after the contaminated food is consumed, with acute symptoms including vomiting and severe abdominal cramps without fever, usually lasting 3 to 6 hours and rarely more than 24 hours.

Shigella

Shigella is associated with contaminated food and water, poor sanitation, and crowded living conditions. Among travelers to developing countries, *Shigella* is a common cause of diarrhea. The bacterial toxins affect the small intestine, with symptoms of food poisoning by *Shigella* occurring 36 to 72 hours after consumption. Symptoms

differ slightly from those associated with other food-borne bacteria, with nausea, vomiting, abdominal cramps, chills, and fever occurring in addition to diarrhea. Children with severe infections may show neurological symptoms, including seizures caused by fever, confusion, headache, lethargy, and a stiff neck, resembling meningitis. The disease generally lasts 2 to 3 days but may last longer.

Escherichia Coli (E. coli)

Many strains of *E. coli* exist, and not all are harmful. The strain causing the most severe food poisoning is *E. coli 0157:H7*. Food-borne *E. coli* is transmitted mainly in food derived from cows, such as raw milk and raw or rare ground beef, as well as fruit or vegetables that are contaminated. Symptoms of food poisoning from *E. coli* appear more gradually than those caused by other food-borne bacteria, as it produces toxins in the large intestine rather than higher up in the digestive system. One to three days after eating the contaminated food, the individual begins to have severe abdominal cramps and watery diarrhea that becomes bloody within 24 hours. There is little or no fever, and vomiting is rare. The bloody, watery diarrhea lasts 8 days or less in milder cases.

Calicivirus

Calicivirus is a common cause of food-borne illness but is rarely diagnosed because the laboratory test is not widely available. The ingestion of this agent leads to an acute gastrointestinal illness, generally causing more vomiting than diarrhea, and ends within 2 days. It is believed that these viruses primarily spread from one infected person to another, unlike many other food-borne agents that are transmitted through animals and animal products. Infected individuals can also transmit the virus to other individuals when processing or preparing foods.

Toxic Food Contamination

Food poisoning caused by toxic agents occurs when there are harmful chemicals or toxins in a food, such as poisonous mushrooms, improperly prepared exotic foods, or pesticides on fruits and vegetables. Chemical contaminants in food often visibly affect consumer health and well-being only after several years of prolonged exposure at low levels, manifesting in diseases such as cancer. Whereas most microbiological agents are affected by thermal processing, chemical contaminants are not.

There are several types of chemical contaminants, which are classified by their source and the way they enter food products. Environmental contaminants are chemicals within the environment in which the food is grown, harvested, transported, stored, packaged, processed, or consumed. These can be chemicals found in the air, water, soil, packaging materials, or processing equipment. Chemicals that are intentionally added to foods during processing, generally for economic, nutritional, or safety reasons, are called food additives. The use of food additives in a manner inconsistent with their intended use can result in undesirable levels in the finished product, possibly exerting unfavorable effects on the food product or consumer health. Processing contaminants are generated while foods are processed, forming as a result of chemical reactions between natural and/or added food elements during processing. Trans fat is an example of a processing contaminant. Agrochemicals are used in agricultural practices and the practice of breeding and raising livestock. These include pesticides, veterinary drugs, plant growth regulators, and bovine somatotropin.

Patti J. Fisher

See also Causes of Death, Contemporary; Causes of Death, Historical Perspectives; Mortality Rates, Global

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Forensic Anthropology

In 1977 the American Board of Forensic Anthropology was established, and in the year 2007 there were over 70 certified diplomates. Forensic anthropology has evolved into a legitimate discipline and has become a part of American popular culture as evidenced by the proliferation of novels and television programs featuring forensic anthropologists.

The primary definition and focus of forensic anthropology involves the discovery, recovery, examination, and analysis of human skeletal remains in a legal investigation or in a humanitarian situation as performed by physical anthropologists trained in anatomy, osteology, pathology, and odontology. The origins of forensic anthropology can be traced to the work of medical doctors and human anatomists who, upon looking at a cadaver, tried to determine the sex, age, stature, ancestry, and in some cases cause of death. History is filled with the names of anatomists and physicians who stood ready to question the cause and manner of death and identity of an individual. Even Paul Revere identified a set of dentures found in an exhumation, made of hippopotamus teeth and silver wire that he himself had made for the deceased Dr. Joseph Warren who was killed at the battle of Bunker Hill and buried in an unmarked grave by the British. This identification enabled Dr. Warren to be reburied as a hero.

The earliest progenitors of modern forensic anthropologists were individuals who practiced chemistry, anatomy, and medicine who also were interested in archaeology. Offering to assist in the study of skeletons of prehistoric Native Americans, one such individual, Joseph Jones, investigated the prehistoric Native American remains from stone box graves in Tennessee. This early examination of skeletal remains included the measurement of crania and comparison of these measures to cranial measurements provided by Samuel George Morton's earlier efforts. More importantly, Jones noted cultural modifications of the skeleton and described the pathology present on the bones, even making thin sections of bone to analyze bone microstructure. During the 1920s anatomist T. Wingate Todd of Western Reserve University would further advance the development of forensic anthropology by continuing the work of Carl August Hamann in assembling a collection of human skeletons from modern cadavers; this collection now numbers well over 3,000. Each skeleton was examined with sex, age, stature, and ethnicity noted. Data on the individual's birthplace, occupation, and probable cause of death also were recorded, and photos of the cadaver taken prior to dissection were included in each skeleton's file. This collection was to prove useful in developing a standard for looking at the changes on the surface of the pubic symphysis of the pelvis and the degree of suture closure on the cranium to determine age at death.

Much of the early development of forensic anthropology started in the 1930s and 1940s, with continued analysis of Native American skeletons by physical anthropologists associated with museums and those associated with Franklin D. Roosevelt's New Deal programs. Physical anthropologists practiced forensic techniques on Native American human skeletal collections, but rarely were these individuals asked to help in a forensic investigation including skeletal remains. Charles E. Snow, however, attempted to replicate prehistoric Native American cranial deformation using the head of a modern cadaver.

In 1939, Wilton M. Krogman published an article on identifying human skeletal remains in the *FBI Law Enforcement Bulletin*, and this publication would soon lead to an ever-increasing role of physical anthropologists in criminal investigation. Later, Krogman's book *The Human Skeleton in Forensic Medicine* would become the standard textbook for the study of forensic medicine.

World War II and the conflicts in Korea, Vietnam, Iraq, and Afghanistan have all increased the need for forensic anthropologists who, in turn,

have refined their methodology. In 1947, a laboratory was established in Hawai'i to identify casualties from World War II. A representative from the Smithsonian Institute, anthropologist T. Dale Stewart, assisted in providing identifying information for both the U.S. government and the Federal Bureau of Investigation. Based on these experiences Stewart edited a volume titled *Personal Identification in Mass Disasters* in which further refinement of aging, sexing, and stature methods are found. "Mass disasters" would prove to be prophetic, as forensic anthropologists began to assist in identifying those who died as a result of terrorist activities, plane crashes, space shuttle explosions, war atrocities, mass graves, and genocide. Today forensic anthropologists are counted among the members of the national Disaster Mortuary Operational Response Team.

A physical anthropologist at the University of Tennessee, William Bass, made the identification of human remains more easily understood through classroom instruction and archaeological fieldwork through the creation and subsequent update of a manual that included drawings for identifying bones and all the requisite standards for evaluation of aging, sexing, and determining stature of a skeleton. Today forensic anthropologists are involved in the recovery of crime scene data ensuring the security of such data. And in places such as "body farms," donated cadavers are placed in different environmental conditions (buried or unburied) and the decomposition of the remains is monitored as to a body's taphonomy (modification of remains after death by animals and natural forces and elements), entomological interaction, and relationship with botanical species. Information pertaining to postmortem interval or time since death is quite valuable within the judicial system.

The work of forensic anthropologists encourages the development of better analytical techniques to determine the age of fetal, infant, and child skeletal remains. Much of the work on the appearance and characteristics of violent, accidental, occupational, and chemical bone trauma is through the analysis and experimental work of forensic anthropologists, some of whom use facial reproduction to identify previously unknown skeletons.

Forensic anthropologists also contribute to the investigation of a crime scene where a fire has occurred through a protocol for search and recovery of the cremated remains. New methods of analysis of the effects of fire on bone also have evolved through these experiences. Perhaps even more valuable is the work that distinguishes whether evidence of inflicted violent trauma found on cremated bone was perimortem or postmortem.

Keith Jacobi

See also Body Farms; Causes of Death, Contemporary; Cremation; Popular Culture and Images of Death; Putrefaction Research

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Forensic Science

Forensic science is a broad field, encompassing a range of sciences, that exists to meet the demands of the legal system. It emerged as a distinct field in Europe and the United States at the end of the 19th century in response to legislative changes that increased the status of evidence over and above testimony. The shift toward evidentiary trials called for a class of experts able to identify, collect, and document evidence left at crime scenes. In cases of suspicious death, their expertise extended to the study of the corpse in order to make formal identifications and secure evidence to assist the investigative process. Forensic science is, therefore, a specialized knowledge that is intimately connected with death and, since its rise in the 19th century, has shaped the law, reinforced the value of evidence, and mediated cultural attitudes toward human remains. Further, the cultural and political role of the dead body itself has been transformed as a consequence of the power

of forensic technologies to invest it with a singular truth-telling power.

From Sherlock Holmes to *CSI*

The detective novel developed as a genre in the 19th century alongside forensic science and played a crucial part in educating the public about the potential for the new science to assist law enforcement agencies. Famously, Arthur Conan Doyle's fictional detective, Sherlock Holmes, adopts a forensic approach to solve mysteries and track down criminals, and he is often seen analyzing footprints, fingerprints, and other trace evidence left at crime scenes. Not only did Doyle's narratives help to popularize scientific theories and techniques, but on occasion they even anticipated the use of procedures in scientific police practice. Their fantasies of social control created a fecund ground for the eventual adoption of the actual technologies, such as fingerprinting.

This entanglement of forensic science with narrative is not unique to the fin de siècle but is a notable feature of the 20th and early 21st centuries. For example, novels by Patricia Cornwell center on a forensic scientist, the Chief Medical Examiner Kay Scarpetta, and the U.S. television series, *CSI: Crime Scene Investigators* and its spin-off shows have achieved global popularity. Forensic science—its empirical methods and technologies—is, thus, peculiarly resourceful for crime narratives and, in turn, such narratives help legitimize it, raising its profile and rendering it accessible to a wide audience. It therefore stands out from other sciences, whose purposes and practices remain more obscure for the public, as a result of the prominent position it holds in popular culture. In fact, the prevalence of forensic science in fiction and television dramas has given rise to a condition termed the "CSI effect." This refers to the public's raised expectations of the field in legal situations, national and international, in turn contributing to further increasing the status awarded to material evidence in trials and bolstering the authority of forensic scientists.

Undoubtedly, one of the main factors determining such an abiding and widespread cultural interest in forensic science is its unique power to make sense of suspicious deaths. Although it is an ever-expanding and evolving field, including specialist areas as diverse as ballistics and entomology, autopsy is, perhaps, the practice that has come to epitomize it in the popular imagination. An autopsy is a medical procedure conducted by a pathologist involving the examination of both the exterior and interior of a corpse to determine the cause of death. Hence, a degree of ambivalence surrounds the forensic pathologist: His or her knowledge can assist criminal cases and grieving families, yet it is acquired by transgressing cultural taboos, violating the body, and awakening age-old fears of interiority. The popular interest in forensic science is a feature, therefore, of a broader fascination with the corpse and transgression of the body's boundaries, with expressions of the provisionality of identity. It is also a manifestation of an intense cultural desire to explain suspicious deaths. Forensic science offers the hope that the dead have not died in vain by paving the way for greater understanding of particular medical conditions and for justice.

Notwithstanding its unique role in making sense of suspicious deaths, forensic science overlaps with a number of other scientific disciplines besides medicine, such as biochemistry, biology, and bioinformatics, and cannot be considered in isolation from them. The roles associated with the field also vary widely, as does the training required to perform them. To illustrate, scene-of-the-crime investigators in the United States (scenes-of-crime officers in the United Kingdom) receive on-the-job training to enable them to gather and document forensic evidence, whereas to become a forensic pathologist a considerable amount of training following a degree in medicine is required.

Forensic experts—in particular, forensic pathologists—mediate between the dead and the public. They claim to speak on behalf of the dead and, by disclosing the secrets of their final moments, offer hope to sustain the living. For the victim's relatives, knowledge of the cause of death can help in the grieving process and, in criminal cases, it is pivotal to the process of discovering the identity of perpetrators and is used as evidence in court. In view of the taboos broken by pathologists in their examination of the dead and their transformation of human remains into evidence, it is vital that they legitimate their role; this is achieved, in part, by appealing to the metaphor of speaking for and listening to the dead. This rhetoric of communion

with the dead is especially prevalent in forensic narratives and television dramas. Patricia Cornwell's fictional medical examiner, for instance, frequently draws attention to her special ability to listen to the testimonies of the dead and interpret their messages for both their relatives and the courts.

Over the course of the 20th century, forensic science increased its sphere of influence to intervene in international political and judicial affairs. Its capacity to read the truth about the past in the bodies of victims renders it a powerful tool in investigations into human rights abuses. In the 1980s, the American forensic anthropologist Clyde Snow helped to establish the field in human rights contexts as a result of his work exhuming mass graves in Argentina, Guatemala, and Croatia, among other places. By identifying the dead and establishing the cause of death, forensic scientists are able to provide evidence to convict perpetrators and challenge the historical accounts of political authorities, thus empowering victims and their communities. In addition to the legal value of forensic expertise for human rights organization, it is often privately welcomed by victims' relatives as it helps the mourning process. Without a name, a body cannot become evidence in tribunals to convict perpetrators nor can it be restored to its family for traditional funeral rites.

Forensic science is of interest, as its practitioners are legally empowered to decipher the bodies of the dead to provide accounts of the past. Forensic science has come to occupy a prominent place in the media and popular culture, inflecting the public's relation to the dead body and sustaining the hope of justice.

Sarah Dauncey

See also Accidental Death; Body Farms; Causes of Death, Contemporary; Exhumation; Forensic Anthropology

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FRANKENSTEIN

On June 16, 1816, Mary Wollstonecraft Shelley created one of the enduring myths of modern civilization: the narrative of the scientist who single-handedly creates a new species, a humanoid form that need not die. In her novel *Frankenstein, or The Modern Prometheus* (1818), Victor Frankenstein robs both cemeteries and slaughterhouses in order to suture together a creature composed of dead animal and human body parts, a creature he then animates with the "spark of life." In doing so, he claims he has renewed life where death had apparently devoted the body to corruption. Frankenstein thus realizes the age-old wish of mankind to transcend mortality, to become a god. And like Prometheus, who in ancient myth shaped the human species out of clay and then stole fire from the Olympian gods to give to man, Victor Frankenstein expects to be revered, even worshipped.

But in his hubristic quest to become God, to create an immortal race, Frankenstein constructs a monster that eventually destroys his wife, his best friend, and his baby brother; these events so exhaust Frankenstein that he dies at an early age. Mary Shelley's novel has thus become the paradigm for every scientific effort to harness the uncontrollable powers of nature and the unintended consequences those efforts have produced, be they nuclear fission, genetic engineering, stem-cell cloning, or bioterrorism. The popular conflation of the scientist *with* his monster—such that "Frankenstein" is as often the name of the creature as of his maker—only points to a profound understanding of Shelley's novel in which Victor Frankenstein finally becomes as filled with hatred, revenge, and the desire to destroy as the creature he hunts across the Arctic wastes.

How did the 18-year-old Mary Wollstonecraft Godwin (later Shelley) come to write such a prescient tale of modern science? Two years earlier, on

July 28, 1814, Mary had eloped with the poet Percy Shelley to France. Seven months later, Mary gave birth prematurely to a baby girl, called Clara, who lived only 2 weeks, after which she had a recurrent dream that her little baby came to life again, that it had only been cold, and that she had rubbed it before the fire, and it had lived. Immediately pregnant again, Mary gave birth to her son William on January 24, 1816. Four months later, Mary, Percy, and Mary's stepsister Claire left England to join Claire's new lover, Lord Byron, in Geneva. Kept indoors by the coldest summer in a century following the eruption of the volcano Tamboro in the Indonesian archipelago in April (which threw so much debris into the atmosphere that the sun was literally blocked out), reading ghost stories for their amusement, the four friends decided on June 16, 1816, to have a contest in which each would compete to write the most frightening story.

That night Mary had the "waking dream," or reverie, which provided the germ of *Frankenstein*. Born from Mary's own deepest pregnancy anxieties (What if I gave birth to a monster? Could I ever wish to kill my own child?), her novel brilliantly explores what happens when a man attempts to have a baby without a woman (Victor Frankenstein immediately abandons his creature); of why an abandoned and unloved creature becomes a monster; of the predictable consequences of her day's cutting-edge research in chemistry, physics, and electricity (most notably the experiments of Erasmus Darwin, Humphrey Davy, and Luigi Galvani); and of the violent aftermath of the French Revolution. Psychologically, Mary draws directly on her own childhood experiences of isolation and abandonment after her mother's death in childbirth and her father's remarriage to a hostile stepmother to articulate Frankenstein's creature's overwhelming desire for a family, a mate of his own, and his subsequent violent anger when he is rejected by all whom he approaches, even his maker. By including an image of the murder of her own son William in the novel, Mary articulated her deepest fear that an unloved (and psychologically abused) child, such as she herself had been, could become an unloving, abusing mother, even a murdering monster.

The novel focuses as powerfully on the dangers of science as on Frankenstein's failure to mother his creature. Here Mary invokes her considerable knowledge of recent scientific experiments by Luigi Galvani (whose nephew, in a particularly famous experiment carried out in London in 1803, electrified the body of a recently hung criminal in an attempt to prove that electricity is the life force) to suggest that Frankenstein's success in bringing a creature back to life with a spark of "fire" (both the mythic fire that Prometheus stole from the gods and a spark of electricity) was entirely possible. But Frankenstein's attempt, in Mary's view, violates the laws of nature, of natural modes of procreation and reproduction; he is therefore pursued and punished in the novel by Mother Nature, who curses him with physical and mental disease, denies him a maternal instinct and the opportunity for natural procreation (his creature kills his bride on his wedding night), pursues him with the very lightning he has stolen from her, and finally brings about his death from natural causes at the age of 26. Worse, in his eagerness to work with bigger, simpler pieces, Frankenstein has constructed a creature of superhuman size and strength, one capable of wreaking havoc on the human race. As the creature tells Frankenstein, "You are my maker, but I am your master—obey!"

As *Frankenstein* finally shows, an unmothered child, like a scientific experiment performed without consideration of its probable results, like a political revolution set in motion without control over its participants, can become a monster, one capable of destroying its maker. Implicitly, the novel endorses instead a science that seeks to understand rather than to change the workings of nature, a politics of evolutionary reform rather than sudden revolutionary change, an ethic of care that would attend to the needs of all the members of the body politic. In this way, Mary follows the feminist politics of her mother Mary Wollstonecraft, endorsing her belief in a family politics, in the model of a loving, egalitarian family that can incorporate and serve creatures of every race and size (imaged in the novel in the French De Lacey family and their welcomed Arab guest Safie) as the blueprint for gradual social reform.

Anne K. Mellor

See also Cloning; Ghosts; Taxidermy; Zombies, Revenants, Vampires, and Reanimated Corpses

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Freudian Theory

Freudian theory is a covering term for work in a variety of fields that use key components drawn from Sigmund Freud's conceptual framework. It is not obvious just how Freudian a theory has to be in order to qualify. Freudian theory is linked to the themes of death and dying through Freud's later work, in particular *Beyond the Pleasure Principle* (1920) and *Civilization and Its Discontents* (1930), in which he advanced and then developed the controversial claim that humans have a death instinct (*Todestriebe*).

In *The Interpretation of Dreams* (1899) Freud had little to say about death. In this book Freud treats dreams as representations of the fulfillment of wishes and holds that this provides a pathway toward an understanding of the unconscious. The wishes that are fulfilled in dreams are taken to be, in many cases, sexual in nature, albeit their sexual content tends to be latent or disguised. Wishes are fulfilled in dreams because they cannot be allowed to dominate waking life. In this way, desires of a problematic sort are held in check. However, the relation between desires and constraint or repression is a complex one. We are more likely to have our desires gratified if we can at least delay their fulfillment. Our lives are structured by a pleasure principle and a reality principle, with the latter constraining the former. The reality principle tolerates delays and can redirect our energies into other channels. Dangerous or socially unacceptable desires are repressed and resurface in other guises.

Patterns of repressed and concealed desire become sedimented during infancy and then exert an influence in later life. Most notoriously, a normal pattern of sexualized male attachment to the mother and rivalry with the father can shape an entire life. Explanations of this sort focus upon personal history. They appeal to the idea that humans are the product of their past. That is, they appeal to prior causes rather than end states. Part of the role of therapy is to exert some control over the often unacknowledged influence of the past by bringing it to light. Insofar as death lies in the future, this approach leaves no room for death to play a significant role. Desires of a sexual nature become sedimented in infancy because infants are (in some broad sense) already sexual beings. Desires concerning death cannot do so because children, according to Freud, have no real grasp of death. Children equate death with someone having "gone away." For death to become significant, it would have to amount to a return to some prior condition.

The Death Instinct

Whatever the limitations and problems of Freud's early approach, the idea of the unconscious opened up an important possibility. If our mental life is not transparent, then we may be covertly drawn toward death even while consciously professing hostility and alarm at the prospect. There are some indications that Freud was already leaning toward this view prior to World War I. Immediately after the conflict he published *Beyond the Pleasure Principle*, in which he claimed that the pleasure principle and the reality principle were not deeply opposed to each other because both ultimately operated in the service of the reduction of tension. Both were geared toward the same end.

In place of the previous opposition, Freud situated a life-and-death struggle at the center of a new account of our conflicted nature. A sexual life instinct (Eros) moves us to reproduce and to guarantee survival. Set against it is a death instinct that moves us to *return* to an earlier condition of tension-free stability. Desire here is taken as a state of uneasiness that we want to be rid of. This account allows the return to and mechanical repetition of the past to be brought into harmony with a more teleological (end-driven) orientation toward our future demise. What we are driven toward is not just any sort of death but only the right kind of death, one that is a return and is tension-resolving. We strive to fight off obstacles on the way to the latter. As a result, the death instinct can help

prolong life by leading us to adopt a self-defensive posture when threatened.

Aggression is generally to be understood as the death instinct directed outward toward others as obstacles. Self-destructive behavior, by contrast, is to be understood as the death instinct directed inward toward the self as an obstacle to the right kind of death. These two can be traded off against each other on both an individual and a broader social scale. The aggression and self-destructiveness of individuals are related. So too are war and national aggression. They can be a nation's way of avoiding self-destructive internal feuds by redirecting their energies elsewhere. This rather sanguine view of the death instinct was developed in more detail in *Civilization and Its Discontents*.

Reception of the Theory Among Freudians

One qualification that is frequently made is that the translation of *Trieb* as "instinct" is misleading and that "drive" might be more accurate. Unlike instincts, *Triebe* are influenced by the social environment and are not biologically predetermined. A death drive that is not a biological given may be shaped or transformed. The energies that it draws from might be channeled in some more productive way. Freud's own views on this matter are unclear.

Among orthodox Freudians the reception of the Todestriebe was mostly critical. Otto Fenichel claimed that appeal to a death instinct was not necessary or useful. In *The Psychoanalytic Theory of Neurosis*, Fenichel acknowledged that it made sense to think of life as a process that led to death, but the positing of an actual death instinct was not needed to make sense of aggression and self-destructiveness. It was, instead, an interesting metaphysical conjecture. As such, its clinical-therapeutic implications were unclear. Less orthodox Freudians argued that Freud had confused the genuine destructiveness of humans under capitalism with the human condition as such. A significant part of the subsequent history of Freud's death instinct is its appropriation by critics of capitalism rather than its use as a diagnostic tool for clinical practice. Marxists in particular have been keen to exploit the analogies between the death instinct and the seeds of self-destruction that they take capitalism to contain. In our own self-destructiveness and aggression, we mirror the capitalist system.

Freud's death instinct had some early champions within the psychoanalytic community, but even the best-known defenses diverged from Freud in significant respects. The American psychoanalyst Karl Menninger claimed that each man tried to kill himself in his own peculiar way. But Menninger's account, in *Man Against Himself*, was fairly upbeat in a way that Freud's account never was about the possibility of channeling the energy that went into self-destructive behavior (and suicide in particular) in more productive ways. Willhelm Stekel was supportive but presented a darker picture of the Todestriebe. In particular, he focused on the concept of Todestriebe as a way to displace a good deal of Freud's sexualized account of desires.

Post-Freudians: Klein, Marcuse, and Lacan

When the Todestriebe resurfaced as a major theme in the postwar years, it shaped both clinical practice and social theory. Melanie Klein pioneered the extension of psychoanalytic therapy to children and was firmly of the opinion that infantile aggression and envy in later life were linked to the self-destructive death drive. Her work, while focusing upon children and so restricted to one class of therapeutic subjects, goes some way to answering Fenichel's charge that the Todestriebe has no clear clinical-therapeutic implications.

By contrast, the appropriation of the Todestriebe by Herbert Marcuse and Jacques Lacan lends some support to Fenichel's concern that this is not really a suitable or necessary diagnostic tool. Marcuse was a social theorist of the Frankfurt School, while Lacan was a psychoanalyst. But Lacan's focus was more theoretical than clinical. Both explored the Reichian claim that there was an intimate connection among capitalism, repression, and self-destructiveness.

Whereas Freud had claimed in *Civilization and Its Discontents* that repression was a necessary and socially beneficial way of holding our destructiveness in check, Marcuse linked repression closely to the destructive impulse. In the influential *Eros and Civilization* (1955) he argued that the political struggle against capitalism was the struggle for Eros against Thanatos, life against death. A nonrepressive society would be less destructive and not more so. Marcuse argued that the death instinct was one

of the archaic powers whose identification was one of Freud's greatest insights. His point about this relationship was that capitalism had *allied* itself with the archaic death instinct. This weaker claim made the relation contingent and, at least in principle, possible to sever. This is precisely what Marcuse subsequently claimed was happening where he took the arrival of affluence to indicate that capitalism had managed to realign itself with Eros in the form of the drive to consume and enjoy.

In contrast to Marcuse's attempt at a strong politicization of the Todestriebe, Lacan's return to Freud was less dominated by explicit political commitment. It also questioned any simple equation of Todestriebe with the destructiveness of capitalism. In his seminar titled *The Ethics of Psychoanalysis*, Lacan draws upon Sophocles' *Antigone* with its depiction of the aftermath of the expulsion of Oedipus from Thebes. Lacan highlights the way in which the heroine of the play adopts a moral stance by embracing death rather than moral compromise. She will bury the corpse of her brother even though he is deemed an enemy of the city and this act will expose her to a sentence of death.

Antigone is sentenced to real death, but she also embraces a figurative death of the self which involves rejecting the Theban community that forms the very foundation of her existence. She subverts her own being and is, for Lacan, lodged *between two deaths*: social death and the final death that is associated with burial or (in Antigone's case) entombment. Lacan favors such subversion of the conventional role. But Antigone's subversion is a personal one. It is not subversion of a sort that could readily be taken over by a political movement. To opt for the latter would evade the need for figurative or social death and would simply involve a transfer of allegiance from one master to another.

Lacan's position is characteristically elusive and difficult to classify. It marks a further departure from the familiar Marxist critique of capitalism as peculiarly allied to the death instinct, although it allows that capitalism makes siding with or against the death instinct into a live issue. Little remains of Reich's clear-cut alignment of anticapitalism and Eros. A Reichian approach subsequently resurfaced in Deleuze and Guattari's *Anti-Oedipus* with the claim that capitalism generates the death instinct because it invests in destructive capability at the expense of the maintenance of life.

Popular Culture

Apart from its appropriation by social theorists and the therapeutic application of the Todestriebe by Klein, the idea of a death instinct has worked its way into popular culture. It has been featured as the theme and title of novels and is a background influence upon several films. *Basic Instinct* is sometimes suggested as an example of a film with suitably Freudian credentials. Aggression, self-destructiveness, and sexualized violence all figure prominently in this film.

Tony Milligan

See also Death, Philosophical Perspectives; Death, Psychological Perspectives; Death Anxiety; Good Death; Sex and Death; Suicide; War Deaths

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Friends, Impact of Death of

In a postmodern era when friendship is often more highly prized than in previous generations, many individuals create a family of investment or a family of friends to enhance, supplement, or replace the family of origin. For others, kinship and friendships overlap: "My mother was my best friend" or "John was like a brother to me." Funeral ritual, estate inheritance law, and custom

still favor bloodline for grief recognition, ritual planning and participation, and social support. A friend, although emotionally closer to the deceased than some or all kin, is generally excluded from the inheriting and from making or challenging funeral rituals. Corporate bereavement leave policies rarely recognize grief for a friend. Consequently, some find their grief for a friend—or the intensity of the grief for a particular friend—discounted or disenfranchised.

Friendgrief is significant. Given an estimated 2.25 million deaths per year in the United States, and assuming a dozen friends are impacted per death, the grief of millions of friendgrievers is disenfranchised with dismissive responses like, "She was only a friend."

Individuals grieving for friends have been identified as survivor-friends, hidden grievers, forgotten grievers, and friendgrievers. Friendgrief is complicated for grievers who have not yet found a word or phrase to capture their loss. This entry first reviews the fluidness of definition and impreciseness of the use of the word *friend* and offers a brief discussion of the ways this friendgrief can be enfranchised. Finally, implications for clinical care and social policy modification are addressed.

Friend: The Concept

Historically, death rituals were a tribal experience in which family and friends grieved in tandem. Over the past century, funeral rituals have become primarily family-centered, with nonfamily relegated to the margin. But what does a particular griever mean when using friend in a lament such as "My friend died last week"? Friend is an umbrella word covering a wide variety of friendly relationships. One needs a qualifier to comprehend a griever's use of friend: best friend, old friend, longtime friend, girlfriend, childhood friend, close friend, casual friend, or true blue or longtime friend. The relationship may be so fluid that yesterday's best friend is today's close friend or ex-friend. Three common categories—casual friend, close friend, and best friend—are complemented by synonyms such as pal, confidante, best bud, buddy, mate, and compadre.

The absence of a straightforward definition for friend creates confusion. Dictionary definitions generally emphasize non-blood-related, nonmarried, and nonsexual relationships. Many, however, would challenge the exclusiveness of that definition—"but I consider my spouse to be my best friend."

Until recently, researchers were unaware of, or unconcerned for, the large population of grieving friends. Grief recognizes no boundaries of law or kinship and is a reality for those who friend and who have been friended. As the baby boomers die, large numbers of survivors will face grief over long-term friendships. Many will discover that the emotions stimulated by a friend's death can be as or more severe than grief for family members. Some friends' grief will be disenfranchised, or the intensity or duration discounted, even by co-friends or mutual friends.

Friendgrief is stressful for individuals who have few friends or who do not know how to make, maintain, or enhance friendships. Some individuals, particularly males, have few or no friends. Some grieve for past friendships that have ended or ended badly; grief can be heightened when friends were estranged. Thus, the death of a friend in a sparse friendship network challenges the griever, particularly when the spouse was the best friend or only friend. Many males acknowledge, "My wife is my best friend." The death of a wife is a dual loss. Ironically, the deceased may have been the friend to whom an individual would have turned for emotional comfort and support.

The loss of a friend is troublesome in the stereotypical masculine professions, such as the military, police, fire, and emergency service providers, in which friends die in traumatic incidents. The colleague, because of the shared potential of harm, becomes a buddy. The friend may be encouraged to disenfranchise public expression of grief to maintain unit cohesiveness. Some assume that outsiders to their profession cannot understand their particular grief.

Harold Ivan Smith has conceptualized that friendships function like orbiting planets around a magnet-friend; some orbits are tight; others illustrate friendship contacts that are less frequent but nevertheless valued. Friends may not have seen each other for some time but report, "We just take up where we left off." Some friends are friends through a shared friendship: Jan knows Ken because each is a friend of Susan. If Susan dies, Jan may or may not continue to be friends with Ken. Over time, one, or both, may delete the other from

their friendship roster. Some individuals have friendships through marriage or partnership. After a married friend's death, the foursome friendship cannot survive as a trio of friends; the deceased may have been the "glue" of the friendship. Some assume the promise, "We'll be there for you," to be a social coupon. Over time it becomes apparent that the promise-makers were more friends of the deceased than of the survivor.

After a death, friendships are reevaluated, reaffirmed, or reconstituted. Indeed, after a death, friends may actively solicit a commitment, "We've got to stay in touch" yet drift apart.

Within friend networks, subgroups of particular friends interact—whether college friends or war buddies that occasionally gather for reunions or workplace friends who go drinking after work. Thus, a memorial may be the first gathering of the deceased's extended friend network with conversation starters such as "And how did you know the deceased?"

Conceptual and Practitioner Perspectives of Friend

The grieving process may be hampered when a family's recognition of a friend of the deceased is at odds with others' perceptions. One family, following an adolescent's drug-related death, asked the funeral director to keep "those so-called friends of his" from attending the services. Nevertheless, these friends needed some ritual opportunity to confront the reality of their friend's death and their emotional reactions. Definitions of friendship shape expectations of support. In U.S. culture a friend must not complicate, overshadow, or undermine the family's recognition as chief mourner(s).

Generally, friends are expected to "be there" for the family. Friends offer—or may be expected to offer—condolence assistance through notifying other friends, offering advice if requested, providing transportation or lodging for out-of-town family members, sending flowers or donating to a designated charity, sending expressions of sympathy (cards, letters, or e-mails), preparing/donating food or providing meals, and attending rituals. Family grievers may assume that all promises of future assistance are collectable and may, after failure to meet expectations, reassess the friendship, "Some friend he turned out to be."

When family members are estranged and the deceased, while alive, had taken on friends as his or her "new" family, navigating the legal, emotional, and ritual impacts can be daunting. Friends who immerse themselves in assisting the family—acts that friends are expected to offer—may distract themselves from their own grief. Some may be tempted to "out-compassion" other friends. However, excessive "thereness" for the family, or for other friends, can lead to complicating one's own grief.

Friendgrief as a Disguised Sorrow

As a consequence of family dysfunction, some individuals create families of investment and invest emotional energy in, and receive support and nurture from, friendkin. The television series *Friends*, a popular television sitcom, portrayed a de facto family. Lesbians and gays establish, value, and maintain families of choice composed of friends, sometimes including ex-lovers.

Friendships are escrow relationships for times of stress. The childless elderly may first turn to friends for assistance. Thus, deaths in these invested friendkin are unrecognized, or underrecognized, particularly by the families, by the manufacturers of social expression, and by those who administer corporate bereavement policies. Managers and workplace colleagues may not recognize, appreciate, or comprehend the intensity of the grief following a friend's death.

Senior adults may experience an underrecognized bereavement overload due to the shrinking diminishment or blurring of their social support network. One elder captured this reality in this way: "A whole lot of people are leaving here. And each one takes another piece of me." Elders are saddened by the latest death of "yet another" friend's death; a memorial service may stir subtle wondering: Who will be next?

Gay and lesbians in the 1980s and 1990s were particularly battered by AIDS-related deaths. Some lost cadres of friends before pharmaceutical developments prolonged life. Grief for friends was heightened by the fear "I could be next" and the anxiety "Who will be there for me?" Grief was also complicated, particularly for closeted gays, by subsequent social stigma and calls for punitive quarantine. On the other hand, AIDS mobilized

and strengthened support services offered by friends and began to challenge hospital "family-only" visitation policies.

In some inner-city neighborhoods, adolescents repeatedly experience friendgrief resulting from violence, substance abuse, and gang behaviors. Some adolescents fear that their friends will not live to be their friends in adulthood.

Friendgrief may be complicated by individuals who want friends to "remember me as I was" and thus discourage visiting. Individuals may be denied good-bye experiences by a family's interpretation of hospital visitation policy. Consequently, friends may feel a particular need to express good-byes through attendance at memorial rituals.

The family/chief mourner may ignore or amend the deceased's wishes, oral or written, to limit ritual participation by friends or even to exclude certain friends from attending rituals by using the phrases "services will be private" or "family only" in newspaper obituaries or death notices. This decision may be further offensive when a family then permits certain friends to attend.

Implications for Clinicians

Personal experiences of friendship, death, and bereavement influence clinical practice. Clinicians must set aside personal understandings, shaped by their experienced friendships, to enfranchise a client's friendgrief. Just as a patient defines pain, the client defines friendship and the subsequent friendgrief.

The most meaningful friendships cannot be captured in intellectual terms but rather through stories. Narrating a friendship's highs and lows offers a means to witness the richness of a particular friendship and provides insight into the grief experience.

Clinicians must re-enfranchise grief experiences that were dismissed, discounted, or disenfranchised—particularly by deaths that confront one's sense of immortality, invulnerability, or assumptive worldview. This is particularly important for children, adolescents, and young adults. An individual may be the only friend in the orbit embracing this intensity of grief; continued engagement with the grief may isolate the griever from others in the friend network. Individuals may use chemical substances or unwise behaviors to "medicate" their sorrow.

Thorough grief for a friend needs to be honored in a "grief-lite" society. If the event is the first significant exposure to grief, the griever may not recognize his or her emotions as grief. By naming this grief, the clinician may help the friendgriever explore ways to maintain a continuing bond or to memorialize the friend. The clinician has the opportunity—in a culture that wants, even pressures, grievers to "move on"—to encourage the friend to "move into" the grief.

Harold Ivan Smith

See also Ambiguous Loss and Unresolved Grief; Bereavement, Grief, and Mourning; Communal Bereavement; Disenfranchised Grief

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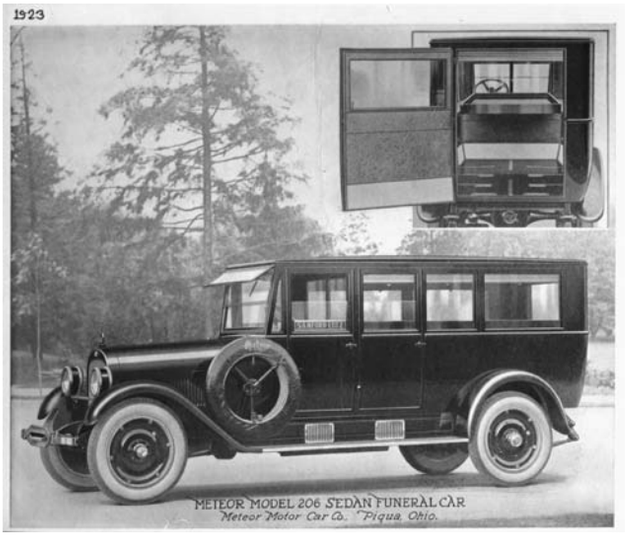
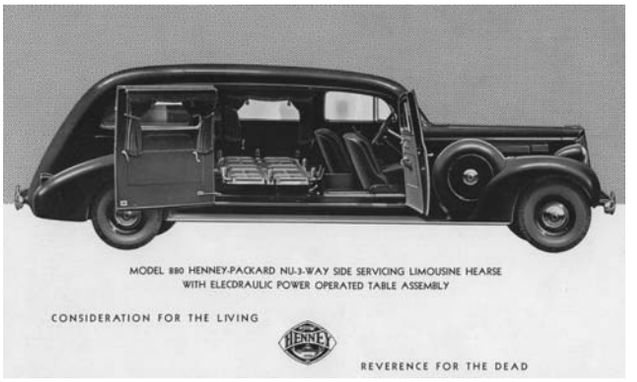
Funeral Conveyances

The first dedicated funeral vehicles are thought to be the sledges of ancient Egypt appearing in tomb art. Greek historian Diodorus Siculus described the richly decorated four-wheeled carriage that transported the golden coffin of Alexander the Great in 323 B.C.E. *Hearse*, the word used for contemporary funeral vehicles, originated from the rake or hirpex used by Roman farmers (also called a harrow in Saxon England or a hearse following the Norman invasion of 1066), which



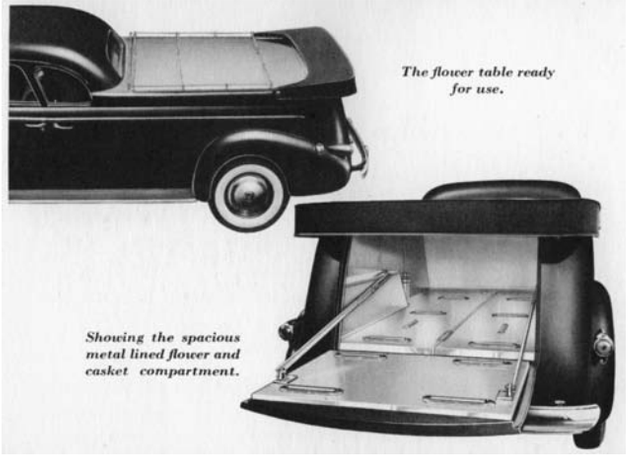
Compared to the wood-intensive, carved-column hearses that descended visually from horse-drawn vehicles, steel-paneled limousine-style funeral coaches like this 1923 Meteor Model 206 offered a completely modern silhouette that complemented other cars in the funeral procession.

Source: Gregg D. Merksamer collection.


MODEL 880 HENNEY-PACKARD NU-3-WAY SIDE SERVICING LIMOUSINE HEARSE
WITH ELECDRAULIC POWER OPERATED TABLE ASSEMBLY
CONSIDERATION FOR THE LIVING
HENNEY
REVERENCE FOR THE DEAD

Three-way hearses, which first appeared in the late 1920s, employed a Y-shaped track that allowed a roller-covered casket table to emerge from either the side or the rear of the body. The system's curbside capabilities reduced loading height for the pallbearers and freed them from stepping into unpaved or muddy streets during the funeral service. This Henney-bodied 1937 Packard further enhanced convenience with an "Elecdraulic" power table.

Source: Gregg D. Merksamer collection.



The first purpose-designed flower cars appeared in the late 1930s to replace the open touring cars and phaetons that had previously ferried floral tributes in the funeral procession. Open well models were dubbed "Western-" or "Chicago-" style flower cars because livery services in the Windy City were among the first to use them, while "Eastern" style flower cars like this 1940 Meteor LaSalle had opening rear doors or tailgates that could admit a casket when the hydraulically inclined deck was in the horizontal position.

Source: Gregg D. Merksamer collection.

The significant growth in U.S. cremation rates has compelled coachbuilders to introduce optional urn carriers that allow the hearse to maintain a ceremonial role in a casket-less funeral. The marble-finished composite Urn Enclave on this 2007 Eagle Lincoln can be quickly detached from its slide-out casket table, while other hearses use a permanent design that pops out of a well in the rear floor.

Source: Gregg D. Merksamer collection.

resembled the candelabra of Norman funeral services when it was inverted and held aloft. Placed on the coffin lid during the funeral procession, this candleholder gradually grew in size to accommodate new saints and holidays, and evolved into a wheeled vehicle by the 16th century.

Purpose-built funeral conveyances became common in the United States during the second quarter of the 19th century, when local churchyards were superseded by large landscaped cemeteries on the outskirts of cities and the undertaker transitioned from a carpenter or furniture maker who made coffins as a sideline to a full-service professional who hired vehicles. Their horse-drawn equipment underwent major design changes fairly infrequently, but one major change that occurred during the 1870s and 1880s saw the narrow-bodied, oval-glassed hearses that had dominated for the previous half century eclipsed by more ornate creations touting intricately carved columns, roof-mounted urns, and tasseled draperies for the casket compartment. Guided in its vehicle selections by newly available trade journals, the typical funeral firm might also operate a plain or sunburst-paneled service wagon for "first calls" at the railway station or the home of the deceased, a fleet of mourners' carriages, and a small, white hearse for the funerals of children.

With few exceptions, the funeral trade was among the last to employ horse-drawn vehicles in large numbers. Many cemeteries banned gasoline engines because of noise, soot, and smell, and electric vehicles lacked the range to take a casket to a city's outskirts. It was not until January 15, 1909, that America's first entirely horseless funeral procession was staged in Chicago, Illinois.

As the trade journals published accounts of motor cars entering funeral service across the nation, the long-established builders of horse-drawn hearses took notice. Crane & Breed, a Cincinnati, Ohio, company that had introduced America's first metallic burial cases in 1853, was the first to announce a commercially produced, gasoline-powered motor hearse in 1909. Though the driver's seat was open to the elements, the vehicle's novelty was emphasized with an unusual rooftop sculpture inspired by the tomb of the Roman general Scipio. James Cunningham, Son & Co. of Rochester, New York, a renowned carriage maker since 1838, quickly followed suit with a semi-closed auto hearse unveiled later that same year.

While an Ohio-built Great Eagle made headlines by completing the first transcontinental auto hearse trip between San Francisco and New York City in 1913, horse-drawn funeral vehicles continued to outsell motor-driven models by 8 to 1 as late as 1915. The first auto hearses cost $4,000 to $6,000 while horse-drawn could be purchased for around $1,500. However, the motor hearse was easier to handle and stop than a horse-drawn one, and could justify its higher purchase price by handling more funerals in a given time frame.

Even if fully enclosed driver's compartments had became common by the time the gasoline pump displaced the feed loft in the mid-1910s, early auto hearses maintained a strong, Victorian-style visual resemblance to horse-drawn vehicles, with their intricately carved columns and drapery panels, beveled glass windows, and brass or silver-plated carriage lamps that might measure 4 feet tall on the more expensive coaches.

Because the hearse had to be longer and heavier than a standard passenger car, most early motor hearse makers assembled their own chassis using mechanical components such as Continental engines, Borg Warner transmissions, Timken axles, Eaton gears, and Delco electrics. This remained standard practice until Cadillac, Buick, and Packard began offering factory-built, long-wheelbase "commercial" chassis during the 1930s, though coach builders typically added their own unique trim and badges to the hubcaps, grille, and bumpers.

By the mid-1920s, automobiles were fully accepted aspects of the funeral procession and metal replaced wood as the most popular body material. Further encouraged by the advent of "combination" coaches that could be used as part-time ambulances, morticians gravitated to "limousine-style" hearses that resembled other period autos with their sleeker silhouettes, plain steel exterior panels, and full-length side windows that were often used to display flower trays inside the casket compartment. With a second set of side doors, limousine styling also proved ideal for the late 1920s introduction of "three-way" hearses with a Y-shaped track for moving a roller-covered casket table out of the side or rear doors of the coach. This curbside servicing device reduced loading height into the era's tall vehicles and freed pallbearers from stepping into rural community streets that were typically unpaved or muddy.

Limousine styling also proved itself ideally suited to evolving construction methods that culminated in the Superior Body Co.'s 1938 debut of the first all-steel welded coachwork. Instead of using wood, the carved-style hearses revived during the 1930s often employed stamped steel or cast aluminum panels to simplify construction and save weight. Another body type that became popular during the 1930s was the purpose-built flower car, a pickup-style vehicle that succeeded the open phaetons that had previously ferried floral arrangements in the funeral procession. So-called Western- or "Chicago"-style flower cars added open flower wells, whereas "Eastern-style" flower cars added a corrosion-resistant stainless steel deck that can be hydraulically inclined to accommodate different-sized baskets or placed in a horizontal position to allow a casket to be loaded into the compartment underneath.

Because civilian car production was suspended during World War II, there was huge pent-up demand for funeral conveyances by 1945. It was at this time that the Landau, distinguished by a heavily padded leather, vinyl, or fabric roof covering with opaque quarter panels and S-shaped bows, became the most popular type of hearse. The considerable inflation in new car prices between the prewar and postwar periods also created opportunities for new coachbuilders that produced relatively inexpensive funeral vehicles based on sedan deliveries and the new steel-bodied station wagons.

Whereas the Eureka Co. stuck to wood-framed bodies until the 1957 model year, the introduction of light, durable, and corrosion-proof fiberglass allowed budget market builders to offer a wide variety of body styles without resorting to costly steel tooling, and it also encouraged more elaborate exterior styling. Many coachbuilders eagerly emulated Detroit in their adoption of thinner window frames, wraparound windshields, and two- or even three-tone paint jobs, on top of which Superior offered a pillarless hardtop Beau Monde hearse from 1955 to 1956, and Miller-Meteor's 1956–1958 lineup featured a Crestwood model touting simulated "Mahogatrim" or "Walnutrim" paneling. By the early 1960s, hearse–ambulance combinations reached the apex of versatility with detachable roof beacons, landau panels secured over the rear quarter windows using slots or thumbscrews, and quickly reconfigured interiors featuring folding attendant seats and reversible casket rollers.

During the 1970s, ambulance customers switched to more-spacious van- and truck-based units, and General Motors downsized Cadillac's Commercial Chassis from a 157.5- to a 144.3-inch wheelbase. It was during this period that the annual output of Cadillac-based professional vehicles fell from 2,506 units in 1970 to 864 units in 1979, leading the three leading Ohio coach builders (Miller-Meteor, Superior, and S&S) to go out of business, merge, or reorganize on a smaller scale. After Cadillac introduced an even smaller front-wheel drive hearse platform in 1985, the rear-drive Lincoln Town Car gained a foothold with funeral directors though its dominance of the booming stretch limousine market. Aware that limousines and hearses were highly visibile, Lincoln and Cadillac established the Qualified Vehicle Modifier and Cadillac Master Coachbuilder certification programs to ensure these vehicles met or exceeded their own design standards and remained compliant with federal safety rules.

The vehicles funeral directors used for "first calls," flower transport, and other supporting roles became more diverse in the 1980s and 1990s. Suitable substitutes included Chevrolet and GMC Suburban sport-utilities and the spacious front-wheel-drive minivans pioneered by Chrysler. A number of coachbuilders equip these vehicles for funeral service by adding casket roller racks, plastic flower trays, and removable landau panels that can be slid off the quarter windows for an extra-discreet pickup at a private home or retirement village. Compared to traditional hearses, such conversions can be built from a base vehicle sold through a dealer and, if necessary at a later date, the modifications are almost always reversible.

During the early 21st century the significant growth in U.S. cremation rates has led coach builders to offer optional urn carriers, thereby ensuring the hearse will maintain its traditional ceremonial role in a casketless service. Antique hearses have also proven increasingly popular for the funerals of old car enthusiasts and auto dealers. Horse-drawn hearses are making a comeback among farmers, historians, environmentalists, or those who yearn for simpler days gone by.

Gregg D. Merksamer

See also Cyberfunerals; Funeral Industry

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Funeral Director

The funeral director is the professional in charge of the body handling and the organization of funerals. The tasks of the funeral director include the removal and care of the body, the dressing and placement of the body in the coffin, the supervising of the funeral ceremony, and the transportation of the body. This role involves coordinating a network of religious, medical, and community actors.

The history of the profession is characterized by a process of professionalization and commercialization, with funeral directors seeking to attract clients by devising and offering an ever wider range of services. As well as taking care of the preparation of the body of the deceased and arranging the funeral ritual, funeral directors now provide other kinds of support, not only to the family of the deceased (e.g., bereavement counseling) but also to the future deceased (e.g., through funeral planning), for those who wish to finance and arrange their own funeral in advance.

History

The origins of the modern funeral director can be traced back to the *libitinarius* in ancient Rome. He performed a number of functions, including embalming, providing professional mourners and mourning clothes, and organizing the funeral procession. Although the influence of these practices can be observed in the practices of 20th-century funeral directors in Western societies (particularly regarding the pomp and ceremony), undertaking as a profession goes back no further than the 19th century. Previously handling the dead was not a matter for specialists. When someone died, various members of the community would be mobilized: The livery stable keeper would provide the hearse and the funeral carriages, the local carpenter or the cabinetmaker would make the coffin, and the sexton would toll the church bell and dig the grave. Immediate and extended family, as well as neighbors of the deceased, would undertake certain tasks such as washing and dressing of the body, ordering the coffin, and finally carrying the coffin from the home of the deceased to the church and then, from there, to the cemetery.

Over time, businesses specializing in providing funeral services and supplies began to appear. The funeral director became no longer a mere supplier of equipment—coffins, hearse, pallbearers—but rather a professional playing a useful role in society, an entrepreneur who offered, for a charge, a wide range of services: washing and dressing of the deceased, casketing, transportation of the coffin, as well as provision of all the paraphernalia of mourning. The increasing control of funeral directors was a consequence of both the weakening of community ties and the decline in the influence of the Church, unable to maintain its authority over every aspect of the funeral rites. Moreover, the shifting of the location of the funeral to specialized premises further increased the funeral director's control over proceedings. As homes got smaller, the laying out of the body in the house of the deceased became impractical and more commonly took place in the funeral home, where there was sufficient room for families to congregate. Likewise, embalming, developed in the United States during the Civil War and involving increasingly sophisticated techniques and equipment, gradually moved from private homes to adapted funeral homes.

The professionalization of funeral directing was an answer to the new needs of not only the bereaved but also the funeral directors themselves. Significantly, it was at the end of the 19th century that these professionals started to refer to themselves as "funeral directors" rather than "undertakers," suggesting their growing responsibility in directing the performance of the funeral and in the handling of both the dead body and the funeral ceremony.

Throughout the 20th century, urbanization, the weakening of community ties, the rise of the nuclear family, and the medicalization of old age all contributed to the growing importance of the role of the funeral director. Nevertheless, from the beginning of the century, the wealthy began to reject pomp in favor of simpler ceremonies, and funeral directors suffered the competition from part-time workers. Professionalizing the industry was necessary. Professional associations emerged then, and the sphere of intervention of funeral directors progressively expanded. Today the profession is going through a period of restructuring, with concentration being a dominant trend. Family businesses that emphasize their long-established presence in the community and their personalized relations with their clientele are threatened by the growth of funeral chains.

A Widening Sphere of Operation

The range of services offered by funeral directors has significantly widened. They are now in charge not only of the body—from its removal to its burial or cremation—but also of the organization of the funeral. To satisfy the desire of the family to personalize the ceremony, a wide variety of services and articles are offered, allowing clients to freely choose their own individualized à la carte package. Among the expanding services are embalming, whose purpose is to make the corpse look as lifelike as possible and delay its decomposition. The arguments given by funeral directors in favor of theses treatment have evolved; whereas reasons of public health often used to be mentioned, nowadays funeral directors rely on aesthetic and psychological considerations, quoting bereavement experts who stress the importance of viewing in the grieving process. The treatments administered result in the "beautification" and "humanization" of the body, supposedly enabling the bereaved to keep a dignified image of the deceased. As the viewing has become more common, particularly in the United States, the use of techniques to treat the body has become increasingly a matter of routine. In charge of the preparation of the body, funeral directors gain greater control over the whole after-death process and develop technical, but also relational and symbolic skills; their expertise in the handling of both the deceased and the bereaved is claimed as a sign of professionalism.

Their role also expanded to the ritual sphere. It is increasingly common for funeral directors to be in charge of the funeral ritual, especially when dealing with a cremation or a civil ceremony. They are led to perform a "ritual bricolage," conducting simple ceremonies based on emotion, authenticity, and singularity. As a result of greater competition and the emergence of a profession associated with embalming, funeral directors have been once again forced to redefine their field of expertise. Postdeath services to the family of the deceased are multiplying and may include transporting the bereaved to the funeral and catering at the funeral home; other services may be performed over a long period of time (e.g., upkeep of the grave). Yet the accent is now put on counseling, including both grief counseling and taking care of various administrative procedures.

Finally, funeral directors are increasingly turning their attention to the deceased of the future. This trend is evidenced by the growing popularity of funeral planning, which involves prior financing and organizing of one's own funeral, with a view to both minimizing the inconvenience caused to the family and to ensuring that one's wishes are respected. These pre-arrangements enable funeral directors to "capture" clients in advance and to exercise their symbolic authority by ensuring that the services provided are meaningful for both the clients and, in the future, their relatives. The funeral director usually promotes authentic, personalized ceremonies, in which those people close to the deceased do not feel excluded and do not feel like mere spectators.

Thus, innovations introduced by funeral directors are rationalized as being in the interests of the client. In taking care of body-handling tasks, they relieve society of the responsibility for doing the "dirty work." The embalming and the viewing are presented as being beneficial for the bereaved; the removal of the body of the deceased to the funeral home relieves them of its presence at home; more generally, having an expert manage the whole process is, in many ways, advantageous. Finally, thanks to funeral planning, the family of the deceased is spared the responsibility for paying for and organizing the funeral. A constantly renewed merchandising strategy is, thus, at work.

The more prominent role played by funeral directors in funeral rituals, together with the growing demand for civil ceremonies, creates a relative competition, or at least a delicate collaboration, between funeral directors and the clergy. As the field of intervention of funeral directors has widened, the Church is concerned that its role played in funeral rituals may be threatened by the funeral industry. For those who want to have a funeral ceremony which, though not religious, nevertheless retains some elements of religious symbolism, the funeral director has come to embody a new kind of symbolic authority. Indeed, civil ceremonies conducted by a funeral director borrow some of the terminology and symbolism of Christianity. Indissociable from the sphere of the sacred, the funeral business has to commercialize its services in such a way as to reconcile the demands of the market economy with those of the economy of symbolic goods.

Expectations and Criticisms

In dealings between the funeral director and the bereaved, an element of uncertainty can arise. This is less likely to concern the quality of funeral equipment, which varies little, than the quality of the service provided, which is expected to encompass the performance of their tasks (punctuality, conscientiousness, reliability), their attitude (discretion, respect), and their appearance (dress, cleanliness). Human qualities and psychological balance are required. Funeral directors are expected to be good listeners as well as being empathetic and tactful. Confronted with distressing situations and with the hostility of the bereaved, who find themselves in a position where they have no option but to purchase funeral services, they may suffer from stress and burnout. As a reaction, funeral directors develop defense strategies in order to depersonalize the deceased, such as the use of slang and crude language—which is in sharp contrast to the euphemistic terminology used in the presence of mourners ("loved one" for the body of the deceased, for example). Funeral directors face a double constraint: They must show compassion toward the bereaved and win their trust in a critical situation while keeping sufficient distance to operate professionally.

Since the 1960s, funeral directors have been subject to a certain amount of criticism. Throughout the media, as well as in several bestsellers such as *The American Way of Death* by Jessica Mitford, funeral directors tend to be presented in a negative light, often being portrayed as greedy and cynical individuals who engage in fraudulent and morally reprehensible practices. They are accused of encouraging the bereaved to overspend and taking advantage of the ignorance and vulnerability of clients by selling them services unwanted, but misleadingly said to be required by the law. Already disoriented, the bereaved indeed have no way of knowing whether they are being overcharged for the services provided and are compelled to make a quick decision. Funeral directors are also criticized for their lack of transparency concerning their rates and, more generally, for making a business out of death. Organizations such as the natural death movement in Great Britain are highly critical of the way funeral directors have professionalized and alienated death, arguing that the bereaved are no longer active participants in funeral rituals and ignore the alternatives to commercialized funeral services (DIY [do-it-yourself] funerals, green burials).

To face their stigmatization and challenge the stereotypes associated with their work, funeral directors attempt to stress their professionalism and human qualities. By using various communication strategies and involving themselves in local life, they seek to establish their professional ethics, respectability, and role in society. Their stated objective is to contribute to giving meaning to death by supervising memorable, moving, and meaningful ceremonies, without substituting themselves for the religious actors. Funeral directors claim to guarantee public health, provide a public service, and treat bereaved families with the utmost respect. They also take pains to have the funeral home decorated in such a way as to create a suitably sober atmosphere, devoid of conspicuous signs of economic trade.

Consequently, despite the fact that, by managing the body-handling process, funeral directors perform a valuable role in society, their social status is low. Professionally, they feel unappreciated, sometimes even socially ashamed. The poor public esteem may be explained first by the fact that families know little of what the work of funeral directors actually entails, and second because funeral directors are reluctant to communicate

about body-handling. They would rather emphasize their responsibility in the smooth running of funeral ceremonies or their counseling of the bereaved. Gratification comes from directing "successful" funerals, from expressions of gratitude of mourners, or from the feeling of having a strong social utility. Nevertheless, the professionalization of funeral services has not led to funeral directors enjoying greater social recognition. On the contrary, the role played by funeral professionals has never been so important, but their public image has deteriorated.

Bérangère Véron

See also Embalming; Funeral Home; Funeral Industry; Funerals; Pre-Need Arrangements

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Funeral Home

The funeral home is a business site where the dead are prepared for cremation or burial. It also serves as a location for friends and family members of the deceased to gather for funerary rites. These funerary rites are planned in conjunction with customers who were either intimately connected with the deceased or are legal executors of the deceased's estate. This entry describes the emergence of funeral homes in the 20th century, and the cultural and structural factors that have caused a shift in the organization and provision of services by funeral homes.

History

Throughout most of the 20th century, the postmortem processing and disposal of the dead was articulated in and through funeral homes. This was not the case prior to the turn of the 20th century, when most funerals revolved around the family home and sometimes the church. Up to that point, the ritualized burial of the dead relied on a host of different individuals in different occupations. Wheelwrights who built and repaired wheels for carriages also transported the dead body from the home, to the church, and to the graveyard. Cabinetmakers constructed coffins. Nurses, midwives, and other ancillary health workers cared for the body by cleaning it, laying it out, and, when necessary, keeping it cool. And members of the clergy oversaw the sacralized portion of the rituals. Cremation of bodies was relatively rare until the 1960s.

Emergence of Modern Funeral Homes

A number of factors contributed to the development of the modern funeral home. Arterial embalming for the purpose of memorialization was introduced to the American public during the Civil War. The display of well-preserved corpses, especially of notable figures like Lincoln, helped popularize the practice, and by the 1880s embalming schools and a major trade association, the National Funeral Directors Association, had emerged. Even then, "embalming surgeons" performed their craft with the aid of portable machines that had a

manual pump, and embalming was carried out in the homes of the deceased.

The concentration of populations in cities contributed to the need for specialized facilities into the early part of the 20th century. Urbanization made it increasingly difficult to transport caskets and equipment while negotiating congested thoroughfares, walk-up flats, and smaller city spaces. The introduction of wiring and indoor plumbing made possible the use of electric embalming machines. This development further specialized funeral work and created a need for delimited spaces in which to conduct this work. Furthermore, the medicalization of dying and death expanded beyond the reach of hospitals and into the lives of citizens. This served to rationalize the dying process and consign the dying and the dead to institutions, rather than allowing them to remain in the home. Aligned to some degree with the discipline of medicine, embalming became an increasingly legitimate task and the embalmer was perceived as a skilled technician.

As a result of these developments, funeral "parlors" emerged in the 1880s, and spread across the country over the next 30 years. While funeral homes emerged as specialized sites to conduct the tasks of embalming and demi-surgery (cosmetizing and restoration), it was only in the middle of the 20th century when they became common gathering places for family members to conduct their wakes or visitations and serve as chapels in which to hold funeral services. Funeral home workers began to assume more control over funerary rites in addition to regulating what occurred to a body after death.

A few basic features comprise the physical makeup of a funeral home. The prototypical configuration includes a chapel, one or more visitation rooms, a "prep" room for embalming, a display room for products such as caskets and guest registries, an arrangements room to meet with customers, and a business office. And while in the past most crematories were located at cemeteries or mortuaries on cemetery grounds, about half of all funeral homes currently have a crematory and most of these have a viewing area available to the bereaved. Today, many funeral homes also outsource their embalming to firms that specialize in such tasks. Other funeral homes merely maintain a presence in an office, thereby serving as an arrangements-only firm that connects the customer with third-party vendors.

Regulation of the Funeral Industry

With the exception of the Funeral Rule, which the U.S. Federal Trade Commission instituted in 1984 requiring firms to provide itemized price lists along with other important information for the protection of consumers, funeral homes are regulated by individual states. About half of all states have special licensing for crematory operators but typically do not require secondary education. Many states have separate licensing criteria for funeral directors and embalmers, requiring that funeral directors perform an apprenticeship under a licensed funeral director. Embalmers are required to attend an accredited mortuary services program and earn either a degree or obtain a specified number of credit hours to obtain a license. About half of the U.S. states have a dual licensure system, and most states require that embalmers have at least a 2-year associate's degree from an American Board of Funeral Service Education–accredited program.

Cultural Shifts Affecting Funeral Homes

In the 1990s funeral homes began to change dramatically as a result of a confluence of factors. Secularization, the growing pluralism among religious persons, and a highly mobile population all contributed to more ecumenical and nonreligious funerals. In addition, consumerism became prevalent. Due to a number of economic and marketing factors, a large portion of the population could participate in the mass-production funeral market. Consumers began to expect choice when it came to their purchases, which necessitated a change in the ways funeral companies conducted their business in funeral homes. Furthermore, baby boomers, who were beginning to bury or cremate their parents, are a highly individualistic generation. Consequentially, personalization became a dominant trend in the funeral industry in the 1990s, and funeral homes changed in order to make customizable funeral services available. In the past, clergy and funeral directors led much of the service but increasingly the attendees were being included.

Also during the 1990s, funeral corporations that had borrowed heavily to finance a heightened

period of mergers and acquisitions began to encounter economic challenges. The growing debt, paired with a declining death rate for North Americans, meant that new means for generating revenue had to be discovered. These structural changes, in tandem with the aforementioned cultural changes, affected the appearance of funeral homes. To accommodate customers who wanted to personalize their funerals with multiple speakers and make their funerals more informal, chapels and visitation rooms were outfitted with multimedia systems to play prerecorded music or record services on DVDs.

In an effort to both bolster revenues and attract baby boomers, many funeral homes began to make their spaces appear less distinctive through the removal of wallpaper, furnishings, and architectural elements in order to distance themselves from conventional funeral home appearances. The transition toward making both the interiors and exteriors of funeral homes less funereal and morbid began taking place after 2000. The interiors of such funeral homes often resemble contemporary office décor. Instead of caskets in a display room, many firms only display corner pieces or catalogues. Other funeral homes eliminate the word *funeral* from the signage or advertise their ability to function not only as funeral homes but as facilities for multiple forms of events or meetings. Many funeral homes remove iconography that suggest adherence to one cultural or religious tradition to appeal to a multiethnic and religiously diverse clientele.

With the rise in the cremation rate, which is one third and rising, there is also a subsequent rise in the number of customers who want to forgo funeral services altogether, instead opting for direct cremation, which currently occurs in approximately two thirds of all cremation cases.

Corporatization

The largest funeral corporations control about 20% of the funeral homes in the United States. Their increased presence, especially since the 1990s, represents an important shift in the ways funeral homes are operated. From the corporate side, conditions were ripe for acquisitions because of overall market increases in venture capital and perceived reductions in risk. At the same time, many owner-operated firms had no willing successors, and attrition was on the rise. Such consolidation leveled out by the early 2000s.

Critics of corporatization often charge that corporations overprice their products and overstandardize services. Some critics also worry about hostile takeovers of "mom and pop" firms. When a firm sells out, corporations typically retain the original owner to remain on site, at least temporarily, to oversee the transition and ensure continuity within the community with regard to "good will" value. However, the products and services typically change in these funeral homes.

Many African Americans are concerned over the corporatization of the funeral industry. Funeral homes were among the first businesses blacks could own in the United States, and these firms were deeply embedded in their communities. Black funerals continue to be less affected by secularization than white funerals and tend to be less reserved. African American–owned funeral homes still rely on advertising in church bulletins (in addition to word-of-mouth), attesting to the ongoing ties to religious traditions. Black-owned funeral homes provide embalming services and assistance with arrangements, while the funeral services are typically held in the church.

Clustering Practices

Clustering is a practice that allows several funeral homes in the same market to share resources and reduce expenditures. One funeral home acts as a hub, which can serve as a warehouse for goods like caskets, vehicles, and other necessary equipment. It can also house staff that need not maintain a full-time presence at satellite funeral homes. By centralizing embalming duties to the "hub," the costs of space, equipment, staffing requirements, and upkeep for OSHA (Occupational Safety and Health Administration) standards are reduced. While this integrated structure originated in corporations, increasing numbers of independently owned homes with multiple funeral homes are turning to this approach.

Clustering also results in a degree of specialization, as certain tasks are only conducted at particular firms. This represents a shift from the past in that funeral home staff members no longer engage in a wide variety of tasks; rather, specific tasks are

conducted on a full-time basis. Thus persons designated as funeral counselors perform no embalming and may not oversee a funeral service, and many firms employ full-time, pre-need salespersons who earn commissions for their work. Removal of funeral directors from traditional social relations within their community means that staff can be transferred and relocated, thus representing a shift from when funeral directors were involved in civic groups and other community organizational activities.

Reminiscent of a period when funeral homes were, in fact, actual homes in which funeral directors resided, a few independent family-owned funeral homes staff their facilities around the clock. However, services are increasingly used to take calls after hours. Many decry this transition if only because any delay in beginning the embalming process requires an increased amount of fluids to reverse the effects of decay that begin at the time of death.

Finally, throughout most of the history of the funeral industry, funeral direction and embalming has been a male-dominated profession. However, currently over half of mortuary college graduates are women. Although viewed as a change by some analysts, in the 1800s many of the workers involved in undertaking tasks were women until male tradesmen and embalming surgeons became more prevalent in the preburial tasks. Although some may attribute this increase in the hiring of women to be reflective of job equity factors, critics argue that the shift is attributed to the salience of stereotypical associations with women as more capable of the kind of emotional labor and service work demanded in funeral homes.

George Sanders

See also Caskets and the Casket Industry; Cremation; Embalming; Funeral Director; Funeral Industry; Funerals; Funerals and Funeralization in Cross-Cultural Perspective

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Funeral Industry

The funeral industry comprises professional establishments associated with the provision of funeral ceremonies, held in connection with the wake, burial, cremation, and memorial rites of the dead. This definition includes those related activities required to facilitate the funeral ceremony, including, but not limited to, the transportation of the deceased, the registration of death, makeup of the corpse, embalming, preparation for the wake, the production of obituaries, and equipping the bereaved with commodities required in the funeral ceremony. As such, funeral homes, funeral parlors, funeral companies, corporations, conglomerates, and crematories are included under the umbrella term *funeral industry*. Funeral directors, funeral conductors, cremators, embalmers, and the staff who work in these organizations are the professionals who comprise the funeral industry.

The phenomenon of the funeral industry is neither universal nor homogenous across cultures. The form of the funeral industry depends on the management and control of the dead and the bereaved during the death ritual, within cultural variance. Furthermore, the funeral industry incorporates both commercial and nonprofit organizations, as long as these establishments and those who work in them are specialized in the treatment of the corpse or assist the bereaved with prefuneral, funeral, and/or postfuneral ceremonies. The following discussion of the funeral industry serves to illustrate its past, present, and future through an examination of its emergence, development, and outlook, with reference to some common criticisms.

Emergence of the Funeral Industry

The funeral industry is a product of modernization, urbanization, rationalization, and specialization. In industrialized societies such as Europe, North America, and Japan during the 19th century, the increasing urban population led to high urban death rates. The problem of disposal of this large number of corpses was commonly addressed by the development and promotion of cemeteries outside of cities, reusing cemetery spaces, and by promoting cremation. In all cases, swift disposal of the dead became important for both health and social-cultural reasons. The development of the funeral industry occurred in parallel with the increased importance given to maintaining public health by safely disposing corpses.

A second factor in the emergence of the funeral industry is the attenuation of community ties. Prior to industrialization and urbanization, death was managed by family and community members. When death occurred, the family took care of their loved ones and performed the ritual traditions. The community helped in transporting, digging, and burying or cremating the deceased, as well as providing a coffin and other paraphernalia. Local priests were called upon for religious services, assisted by community members. Communities owned local cemeteries or graves where the dead reposed. Death and funeral performances were an essential communal responsibility that maintained communal solidarity. However, as urbanization progressed, such communal ties weakened as the youth moved to the cities and left their elders behind. As a result, much of the community funeral knowledge was lost.

The specialization of work and the control of knowledge by the funeral industry were outcomes of this attenuation of communal ties. Prior to the emergence of the funeral industry, there were undertakers in urban areas who assisted the bereaved in various tasks such as providing a coffin, digging the grave, and providing the paraphernalia and upholstery for funeral rituals. These were not funeral specialists but nurses, craftsmen, carpenters, cabinet makers, construction workers, liverymen, or carriers, who occasionally extended their routine work skills to a part of the death ritual. The transformation from undertaking/undertaker to a funeral industry can be marked by their full transition to providing specialized services catering for the dead and bereaved, where community members could not provide the required services or where family members willingly relinquished their responsibilities. Major specialized tasks offered by the funeral industry were prefuneral and funeral services such as embalming, applying makeup and encoffining the corpse, registering the death, preparing for the wake, writing obituaries, equipping the bereaved with commodities for funerals, transporting the deceased and family, and providing postfuneral memorial services such as cremation or burial.

Various Forms of Funeral Industry

Tony Walters examined the funeral industry from a global perspective and found that specialized funeral services are performed by commercial, municipal, or religious organizations, or any hybrid of these, depending on their part of the world. In North America, commercial funeral parlors take care of the corpse and performing services at the prefuneral and the funeral. Cremation, as a postfuneral service, is mainly provided by commercial organizations, while cemeteries are managed by community and religious organizations as well as commercial organizations. In Europe and especially France, Germany, and Italy, prefuneral services are provided by enterprises owned by local government, while municipality-owned cemeteries have replaced most of the church cemeteries. Among Jewish and Muslim groups around the world, funerals are prepared and run by local religious groups, and the dead are buried in cemeteries either owned by the religious group or in a religious section of a municipality-owned cemetery, or in a privately owned cemetery. In most societies, the funeral industry is not a singular entity but, rather, a hybrid. It can comprise several organizations, as in the United Kingdom or Japan. In the United Kingdom, the funeral director takes charge of the prefuneral and funeral services, while the corpse is taken to the cemetery, which is owned and operated by the Church. In Japan, the funeral companies take charge of the deceased and the bereaved, from picking up the deceased at the hospital, through the cremation, to the memorial ceremonies. The remains of the deceased are kept in graves or ossuaries in either Buddhist temples or

private cemeteries. In recent years, new practices such as the scattering of ashes have become popular in Japan due to the lack of grave space, the high cost of graves and ossuaries, and more importantly, the lack of inheritors who would worship the grave. Funeral companies began to tailor services for those who want the deceased's remains scattered at sea by arranging a funeral conductor to execute the ritual process and arrange a hired boat.

Hence, the funeral industry emerged from the division of labor, specialization, and the control of funeral knowledge where local community ties attenuated during rapid modernization. Whether organized as a private, municipal, or religious entity, and as a result of urban social changes, the funeral industry took on the necessary task of caring for the deceased and assisting the bereaved through the ceremonial process.

Development of the Funeral Industry

As the funeral industry developed, it came to acquire three defining characteristics: (1) specialization in handling the corpse, (2) standardization of funerals, and (3) offering comprehensive services to the bereaved.

Specialization in Handling the Corpse

One of the most important tasks of funeral staff or directors is the ability to handle the corpse. Firstly, this involves picking up the deceased from a residential house, hospital, nursing home, accident site, or police station. A professional demeanor, being respectful and courteous to the corpse regardless of its condition, is essential. Handling of the corpse also includes cleansing, covering up damages, dressing, makeup, and encoffining the deceased. In cultures where they do not embalm, it is the responsibility of the funeral industry to preserve the deceased (dry ice, etc.) until the end of the funeral ceremony. Introduced into the United States during the Civil War, embalming has penetrated both the U.S. and the U.K. markets today. The development of the funeral industry and the commercialization of death went hand-in-hand with the specialization of embalming. Embalming signifies technology and scientific skills and the authority of its profession. Not only did embalming give expertise to funeral directors, the scientific knowledge they acquired also guaranteed proceeds to the funeral industry. Moreover, the repetitive performance of embalming by the funeral industry brought a proliferation of its custom, which in turn legitimized embalming as part of the American way of death. The institutionalizing of embalming cemented the final viewing of the deceased as part of the funerary tradition.

Not all cultures or funeral industries perform embalming. It was brought to Japan by U.S. funeral directors and morticians in the 1990s, and larger funeral corporations are gradually increasing its application. However, in Japanese funerals, embalming is still performed less frequently than is the bathing ceremony. The bathing ceremony is a reinvention of the ritual that once took place in community funerals. The bathing ceremony does not use technology; it simply washes the deceased in a ceremonial manner. In Japan it is not scientific knowledge but traditional knowledge combined with professional experience in handling corpses that provides legitimacy to the funeral industry. Irrespective of the processes used, it is the culturally dignified treatment of the dead that legitimizes the funeral industry to provide funerals.

Standardization of Funerals

The standardization of funerals takes place in the context of changing social processes; that is, along with similar transformations in other industries, the funeral industry is transforming funerals into an efficient structure, a bureaucratic procedure, and a predictable operation. Over time, the funeral industry obtained funerary and managerial knowledge that allowed it to process a funeral in an efficient manner. Mastering the sequence of the wake and funeral, the funeral industry ushers the bereaved from one stage to another smoothly and with a minimum of interruptions—from transportation of the deceased, getting the death certificate, embalming, preparing for viewing, inviting priests, arranging the burial or cremation through to the postfuneral services. Each stage of the funerary performances is predictable in terms of cost and calculable, allowing the bereaved to select the casket, funeral hall, funeral altar, burial, or cremation with the information supplied by the funeral industry. The funerals are clearly structured, and

each stage of the funeral performance is professionally operated and managed as described by the funeral industry. The number of funerals led by the funeral industry in each culture has produced a standardization of funerals and funerary performances. Thus, the way of death in each culture has become a bureaucratic, rational, and professionally orchestrated procedure rather than an ad hoc process.

Comprehensive Services

The funeral industry offers comprehensive services to the bereaved's family and often acts as a one-stop shop for funerals. The funeral directors guide the bereaved from the deceased's death all the way until the end of the funeral. They transport the deceased, embalm and/or cleanse the deceased in their mortuary, help the bereaved get the death certificate (and possibly cremation permission) from the government or municipality, prepare acknowledgment or notification cards for the funeral, and provide caskets, coffins, urns, or other necessary paraphernalia. Their control of the merchandizing, on display at a funeral home or on the Internet, allows the funeral industry personnel to sell the funeral while in the family's home. This merchandizing, in addition to the handling of the corpse covered earlier, enables the funeral industry to be all-encompassing.

In summary, specialization in handling of the corpse, standardization of funerals, and comprehensive services can be seen as the bureaucratization of death by the funeral industry. Handling of the deceased from prefuneral to the end of the funeral allows the funeral industry to control the perception of death and the funeral process.

Critiques and Defense of Funeral Industry

The public and media have often been critical of the commercialism of the funeral industry, viewing it as dismal trade. One of the strongest criticisms came from Jessica Mitford's 1963 book, *The American Way of Death,* in which she illustrated how the funeral industry manipulated vulnerable customers into purchasing expensive caskets, coffins, and other paraphernalia. She pointed out that embalming in America is a tradition invented by the funeral industry for its profit, and thus it is unethical. The Japanese media has also portrayed the funeral industry as a lucrative business. One example is seen in how Japanese Buddhist priests are regarded. After the 1970s economic boom, the Japanese public and media began to describe Buddhist priests and their temples as total profit-making priests (*bōzu-marumōke*) because of the high price of their funeral services which, to a layman's view, only required the slight effort of chanting Buddhist scripts and providing a posthumous name to the deceased. Such criticism, however, is appropriate only after considering the particular context of cultural, social, psychological, religious, and afterlife values, which in turn illustrate that the handling of death by the funeral industry is not all about commercialization.

One of the reasons for the negative perception of the funeral industry stems from its obligation to provide services during the period when people are vulnerable, in shock, or emotionally unstable. Purchasing decisions made before the funeral can easily be regretted afterward, in which case the funeral industry gets the blame. While some funeral directors may manipulate the vulnerable bereaved to sell more and expensive services, there are many downsides to such excessive profit making. The funeral industry, like any other, needs a good relationship with the clientele and communities they serve to get repeat customers, referrals, and recommendations.

Vanderlyn R. Pine and Derek L. Philips's 1970 study of a U.S. college town with a population of approximately 7,000 showed that funeral costs were higher for deceased who were older or from the middle class than for those who were younger or of lower or higher social classes. These different funeral costs reveal what is important to the bereaved. Hence, the correct amount of funeral expenditure depends on what is considered a decent funeral by the individuals involved, which in turn, depends upon who the deceased was—including the bereaved's social status, religious background, and culture—and when the funeral took place.

Outlook for the Funeral Industry

The current trend within the funeral industry is to personalize funerals within the deceased's cultural homogeneity. In recent years, the commercial

funeral industry has changed from small, family-owned funeral homes to larger, funeral corporations or multinational conglomerates. Irrespective of the organization type, the survival of the funeral industry depends on its ability to adapt to consumer needs. In many cultures, consumers demand a wide variety of funeral types; people want to personalize their funerals. In the United States, death wishes show an increasing rejection of embalming. Instead, the bereaved may want their loved one's ashes made into diamonds or sent to the moon. A number of Japanese housewives wish to be buried, not in their husband's ancestral grave, but in a collective women's grave or to have their ashes scattered under a tree. The funeral industry is an adopter of cultural and social changes, and at the same time, a producer of the new services and products consumers demand. However, the funeral industry does not craft a fusion of global funeral culture. Although the funeral industry may export a ceremonial performance (e.g., exporting embalming from the United States to the United Kingdom, Australia, Singapore, Japan, and elsewhere), and the techniques used are similar across countries, their interpretation and its value in the ceremony are unique to each culture. Hence, the funeral industry will continue to conform to social changes and consumer needs, while creating homogeneity in the funerary culture they serve.

Hikaru Suzuki

See also Commodification of Death; Death Care Industry; Embalming; Funeral Home; Funeral Industry, Unethical Practices; Funerals; Funerals and Funeralization in Cross-Cultural Perspective

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Funeral Industry, Unethical Practices

Family members are particularly vulnerable at the time of the death of a loved one to feelings of guilt and despair. This vulnerability can lead to magnifying the processes of rites and rituals involved in funerary practices. Individuals who are involved in the for-profit funeral industry know these psychological phenomena and find it easy to exploit the vulnerable in order to profit handsomely from providing funerary services.

Widespread ethical problems in the funeral industry were first highlighted by the 1963 muckraking exposé, *The American Way of Death*, written by Jessica Mitford with her husband, Robert Treuhaft. Mitford's book exposed a range of practices seemingly designed to maximize the cost of funerals. They ranged from outright deceptions, such as telling consumers that embalming was a legal requirement, to providing underwear and universal "fitafut" shoes, even when only the upper part of the corpse was to be displayed in a split lid casket. Mitford's graphic description of embalming in particular enraged readers of the book, which quickly became a best seller.

The public outcry that followed its publication prompted the U.S. Congress to hold hearings on the funeral industry. Eventually the U.S. Federal Trade Commission (FTC) issued its Funeral Rule in 1984, which sought to end the secrecy surrounding funeral costs and the practice of forcing all consumers to pay for all services, whether wanted or not. The rule requires that consumers be given complete and itemized cost information for specific services to be provided.

Although the Funeral Rule led to more accurate and easily understood information, the funeral industry adopted marketing practices designed to represent the funeral home personnel as friendly and supportive of grieving families, appealing to a

combination of guilt and gratitude to encourage decisions for more expensive options. The revised practices of a revived funeral industry prompted Mitford and Truhaft to write a second scathing indictment of the funeral industry. In *The American Way of Death Revisited* (published 2 years after Mitford's death in 1996), Mitford adopts a journalistic technique of accurate reporting with devastating effectiveness. Starting with the task of identifying, characterizing, and attracting the customer base, Mitford details everything from the analysis of the ability to pay by the bereaved, the choice of language in describing the services and products offered by funeral homes, the procedures employed in preparing the deceased for viewing, the range of caskets and their strategic array in showrooms and catalogs, to the final item: the vault and the techniques for its sale.

Characterizing the Customer

Funeral directors are acutely aware of the pending financial resources of families that are in the process of dealing with settling the estate of a recently deceased relative. Some of the resources are predictable from the decedent's history of employment. Minimally they include the death benefit from Social Security. Often there are paid-up insurance policies intended for "final expenses"; larger policies, pension benefits, and stock accounts may provide a considerable amount of cash to the immediate family. In a smaller community, the funeral home owner can calculate with great accuracy the available cash and can plan the funerary services to be offered accordingly.

Language

Funeral home directors are trained in their schooling in language calculated so as to build the confidence of the customer in the director's wise counsel. An embalmer is now a "dermasurgeon." Funeral directors have appropriated the title and role of "grief therapist," despite usually lacking any training in clinical psychology. The industry from time to time publishes lists of "in" and "out" words and phrases to be used in grief counseling: These lists are occasionally revised. Since 1916, handling the corpse has evolved from "prepare body" to "prepare remains" or "prepare (decedent's name)." Coffins have become "caskets"; morgues "preparation rooms"; a stillborn child is "your baby/infant"; the dead are now "the deceased"; ashes have become "cremains" or "cremated remains," and so forth. The word *death* is not to be used; thus, a death certificate is a "vital statistic form." Graves are "opened" and "closed" rather than dug and filled. And the deceased have not died; they have "expired." Directors never refer to the cost of the casket but rather speak glowingly of "the amount of investment in the service." And above all, cremation never occurs in a retort or oven; it is a "cremation chamber" or "vault": "language dictated by sensitivity to the bereaved relative's sensitive feelings."

Preparation of the Corpse

Different preparations are needed depending on the state of the body upon death. An individual who has had the fortune to die suddenly in his or her bed still looks gruesome: blood pools in the lowest parts of the body; sphincters suddenly lose their tonus, releasing fecal matter and urine. Many automobile deaths are traumatic, involving loss of limbs or head or torso. Still worse are the results of assault by others. Some difficult preparations are those in which death has followed torturous mutilation. The mortician is thus faced with an enormous challenge to prepare the decedent for final viewing by friends and family, seeking to erase the horror resulting from identification viewing and replace it with a final image more in keeping with the perception that "he/she looks like he/she is sleeping," perhaps the highest compliment to the mortician's artistic skill.

Because bodily decay starts rapidly, a decedent who is to be viewed (and perhaps shipped home first) must be washed and embalmed. But embalming, started during the Civil War so soldiers could be shipped home, is not the procedure of the Egyptians; its aim is to carry the deceased for the few days between death and burial or cremation during which friends and loved ones "say their good-byes." "Grievance counselors" solemnly assure those who remain behind that final viewing is healthy and facilitates the grieving process, even though there have been no adequate controlled studies that provide such evidence.

All this cosmetic work, the replacement of lost limbs, smoothing with wax and airbrushed colors

the face ravaged by injury or savagery, is necessary only if viewing is to occur. And here, social custom and expectation, fanned by such celebrated phenomena as state funerals, dictate that the closer one can approximate such a spectacle, the greater the value accorded to the deceased.

The Casket

Morticians are acutely aware that the single most profitable element in the optimal funeral is the casket. Caskets and cosmetics are essential elements in creating the illusion that the clock has been wound back to before the death event. A decedent well prepared for viewing, perhaps dressed in a favorite dress or smoking jacket, holding a Bible or pipe, wearing the rings and keys and pins of a lifetime of exemplary learning and service, all contribute to the illusion that he or she "is just sleeping."

Morticians' conferences present empirical research on how the display of caskets may be staged to increase the likelihood that a more expensive model is chosen. The array is not by cost, but presents options in an order that seems to deflect attention from price and toward appearance and quality. Tendencies to turn one way or another when entering a room full of caskets have been determined by behavioral studies: As most individuals are right-handed and tend to turn in that direction, more expensive options are placed to the right of the door to the display room. If a customer is left-handed, a door on the opposite side of the display room is the preferred point of entry, so that the natural tendency to turn first to the left will be met by the more expensive options.

The Second Casket

A major part of the illusions surrounding funerary practices is the idea that decay can be held at bay, not merely through embalming, but also through burial in "hermetically sealed" caskets placed in a brick or concrete vault, sometimes lined with lead. Individuals agreeing to these structures usually do so in the belief that they prevent air, water, worms, and bacteria from getting to the deceased's remains. In truth, the vault serves only the interests of the cemetery as it prevents collapse of the soil above the casket as the latter, and its contents, degenerate.

Cremation

Cremation of the deceased became increasingly popular after the publication of the first Mitford work. Cremation can be achieved for a few hundred dollars and does not require a casket. The dead individual can be transported directly from the death bed to the crematorium in a body bag. Ashes, depending on the wishes of the consumer, can be returned to the family in a tin box or in an urn of almost any price. Most states permit ashes to be scattered in public lands or buried in a cemetery or even a backyard.

What Is Ethical and Unethical

When it was discovered that a Tennessee man had accepted money for cremating bodies which he had piled up instead of cremating, everyone agreed that this was unethical. Unfortunately, it is not as easy to get agreement on every practice that an individual consumer may consider unethical.

The major effort of the FTC in enacting rules to regulate the funeral industry has been to stop deliberate misrepresentation by morticians of facts and laws. Telling the bereaved that embalming is a legal requirement, even for cremation, to combat the spread of infectious disease is banned, as are other practices such as not offering a detailed price list of unbundled services. But the FTC makes no requirement that individuals who seek funerary services not be unduly influenced by guilt or the pressure of peer expectations, long a requirement of informed consent in medicine and human subjects research. The result is that, given the psychological sophistication of modern marketing methods and sales psychology, the funeral industry regards itself as ethical when it gives the public what it wants rather than the minimum of what it needs.

The public needs means of disposing of the dead in such a way that public health is preserved. It needs its sensitivities served by proper respect for remains. It needs a place and time for family and friends to gather and memorialize the deceased. All else serves the dubious human characteristics of status and making atonement that is too late.

Still, allowing for the psychological manipulation that any successful salesperson of real estate or automobiles practices, and thanks to the Funeral Rule of the FTC, most practices of the funeral industry do not fall clearly into the category of the unethical. In that respect, the caveat emptor admonition is the remaining protection for the consumer.

The Not-for-Profit Way

Some 200 nonprofit, volunteer-run memorial societies in the United States and Canada provide opportunities for advance planning and guidance at the time of execution of those plans. A small fee paid to one such society entitles the member to the services of any society at the location of the individual's death. Most of these societies belong to the Continental Association of Funeral and Memorial Societies or the Memorial Society Association of Canada. They can help structure such options as a home wake, rental of a casket, and burial without involvement of a funeral home.

A final option is body donation to a research medical school. Cadaver donation is intended for training medical students and advanced study by medical physicians. Donor cards may be obtained from Continental Association of Funeral Memorial Societies, Inc. As a medical school may decline the offer, alternative plans should be made.

Irene E. Leech and Richard T. Hull

See also Burial Laws; Economic Impact of Death on the Family; Embalming; Funeral Industry; Pre-Need Arrangements

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Funeral Music

Associating various kinds of performing arts to the most important events occurring in people's lives is a common feature of human culture. Prayer staging, singing, and dancing are commonly met at solemn occasions such as births, initiation rites, marriages, and funerals, as well as more specific rites of passage as, for example, ordination in some churches. But perhaps the association of these rites and music is nowhere as frequently met as with funeral practices, except in those religious contexts where music as a whole is forbidden, such as in the most radical tendencies within Islam. Singing and instrument playing are universally conspicuous. In Western culture, funeral music has given way to a special musical genre that is commonly called the *requiem,* from the Latin form of prayers dedicated to the deceased in the Catholic Church.

Specialists in the field of rituals as applied to funeral procedures generally distinguish between three types of rituals: (a) rituals of separation: the deceased is said good-bye to by the community as he or she leaves the realm of the living through the words of an officiant (e.g., a priest or a prayer leader of some sort); (b) rituals of translation, from the realm of the living to the realm of the dead; (c) rituals of welcome, at the threshold of the realm of the dead, once again an officiant or a group of welcomers. Music, accompanied or not by songs, can be heard at every stage of the whole set of rituals. In the Catholic Church, the rituals of separation are perhaps the most important since the contemporary funeral corteges have relinquished the pageantry of ancient times and that the burial itself, being held in open air, is rarely an occasion for much singing and music playing. Moreover, except for prominent people, the funeral ceremonies of today are often reduced to some perfunctory praying and speaking. In most cremation ceremonies, however, records are played, which are chosen in accordance with the deceased's tastes. This now occurs also in some religious funerals.

Requiems, From Dufay to Britten

At the beginning and at the end of the sung Mass of the Dead, the officiant begins his last oration by the words "*Requiem aeternam dona ei, Domine*" (Give him/her, Lord, eternal rest). The word *requiem* applies to a special kind of mass, to which many illustrious composers have given their names. Mozart is the best known of them. But others such

as Verdi, Berlioz, and Fauré are also celebrated. During the early stages of Christianity, at funeral services, music for the dead was performed in plainsong. The first original *Mass of Requiem,* of which the score is now lost, is said to have been composed by Guillaume Dufay (1400–1474), a musician from northern France, for his own funeral service. But there are more ancient melodies associated to these Latin texts, such as Gregorian ones, dating back to the 7th century. Traditional liturgical music was often used for scoring the *Requiem* text. As a rule, the lyrics of the Mass for the Dead differ from those of the ordinary Mass. They begin with the word *Requiem* and replace the *Gloria* by a "sequential" beginning with the famous *Dies irae* (Day of Wrath), and the *Credo* by an *Offertium.* In the A*gnus Dei* section, the first line "*ora pro nobis*" is replaced by "*dona eis pacem,*" and the second one, "*dona nobis pacem*" by "*dona eis requiem sempiternam.*" A last section, "*Lux aeterna luceat eis*" (Let everlasting light shine on them) concludes the Mass.

One would expect the musical color of the *Missa de Requiem* to be generally a somber one. This is not always the case, though some of the most famous examples bear a tonality of grief: those of Mozart, Michael Haydn, Cherubini, and Dvorák. But there are exceptions such as Verdi's, where to some extent grievance replaces grief, and Fauré's, which he wrote at the occasion of his mother's death, in which the atmosphere is one of sweet acceptance and resignation. Many of the great composers never wrote a requiem, for example, Beethoven or Johann Sebastian Bach (perhaps because Bach was a devout Protestant). However, Bach wrote a *Mourning Ode* (*Trauer Ode*), and Beethoven a *Funeral March,* ordinarily played in London at the Ceremony of the Cenotaph. Many musical works are related to death and mourning, such as *Funeral Music for Queen Mary* by Purcell, *Funeral Music* (a homage to Béla Bartók) by Lutoslawski, the second movement of Beethoven's *Eroica Symphony* ("Marcia funebre"), Wagner's "Death of Isolde," Hindemith's *Mourning Music* (on the death of King George V), and Penderecki's *Threnody* "to the victims of Hiroshima."

One should also note musical works bearing the title of *Requiem,* but which do not refer to the canonical words of the Latin Mass. Best-known examples are Brahms's *Eine Deutsche Requiem* (with a libretto in German), Delius's *Requiem* (on texts by Nietzsche), and Stravinsky's *Requiem Canticles*. Britten's *War Requiem* is special in that it is set on nine poems by the World War I poet Wilfred Owen in interpolation within the lines of the Latin requiem mass. The feeling of death and grief also pervades a great part of Western music, as in many lieder by Schubert or in Mozart's Masonic *Trauermusik*. Death scenes appear often in the opera, be it Verdi's *Traviata* or Puccini's *La Bohème*.

One may distinguish requiems composed for all the dead from those dedicated to deceased people in particular as individuals or in group. To the first category belong Mozart's and Berlioz's requiems. To the second, Cherubini's one in the memory of King Louis XVI, or as Britten's *War Requiem*.

The music of the *Missa pro defunctis,* apart from its liturgical significance, can also be considered as a musical genre per se, comprising many pieces that are often played at concerts separately, like other kinds of religious music, and masses in particular. It has been stated that some requiems such as those by Berlioz or Verdi were more appropriate to concert rather than church use. On the other hand, musical pieces that do not necessarily convey a sense of grief can be heard at funeral services, sometimes denoting a somber tone, sometimes not.

In contemporary services, recorded or actually performed music may include secular pieces or even pop songs. In 1993 at the funeral service of King Baudouin of Belgium, no requiem was performed but rather a patchwork of classical pieces (Franck's *Panem Angelicum,* among others) and secular tunes from various origins. Postmodernity was well represented at the ceremony, as it has been in many other solemn occasions such as weddings or coronation pageants.

Other Religious Settings

In most religions some kind of music, instrumental and/or sung, usually plays a great role in mourning ceremonies. As a rule, music is called for in many kinds of rejoicing, private or collective, such as weddings, graduations, or dedication ceremonies. But music also is called for in occasions of sorrow, mourning ceremonies being only one example of these occasions. Recollections and various kinds of

tragic celebrations are also accompanied by music in a majority of societies.

Variants of the *requiem* are to be found in the Protestant, Anglican, and Orthodox branches of Christianity. Among the Jewish communities, a special *Kaddish*, sung in Aramean, is performed in funeral services, normally by the local cantor. In Islam, music as a whole is forbidden, but there are prayers said by an imam, or prayer leader, at the mosque. These are more or less psalmodied, which can make them rather akin to *Sprechgesang*.

In other less developed cultures, for example, in sub-Saharan Africa, funeral rites encompass songs and instrumental music, especially percussion. Funeral songs are related to war songs and are also accompanied by dances. These songs are often violent, calling for the reinstatement of a previous social order that death has disturbed. As on other festive occasions, the original chaos is staged from which the social order, surpassing the occasional chaos generated by death, is supposed to evolve. This is especially true of the chiefs' funerals. Anthropological studies of death rituals abound, showing that beneath the many various stagings one may encounter through the vast human realm, a common scheme is always lying. It is the same in every known culture, as well in highly "civilized" societies as in "traditional" ones.

Religious music used to be a compulsory component, as it may be thought obvious, in religious funeral services. Its function was threefold: (1) awarding the deceased a publicly stated religious accompaniment, (2) reasserting the religious affiliation of the deceased, and (3) providing a "beautiful" environment to the occasion. In one of the rare books on death and its social treatment, which rarely deals with the presence of music in funerals, the author M. Bradbury has one of his witnesses declare, "The funeral was absolutely beautiful. We had all the most wonderful music, and the church was full, and that was very comforting" (1999, p. 87). So the function of music, be it a way to underline the "farewell" ritual or the "welcome" ritual, is to bestow an aesthetic dimension that broadens the collective scope of the latter. In music more than in words, the assembled community of mourners is really called to "commune" and also to communicate its sorrow to the external world. Music helps to gather the people around the still-fresh memory of the deceased and is a token of the people's common grief. Thus the music to be sung and/or listened to is an important part of the funeral ceremony and must be chosen carefully.

In nonreligious funeral services, musical pieces are drawn from various sources. For example, Sir Elton John performed a remake of his song *Candle in the Wind* at the funeral of Diana, Princess of Wales. A kind of farewell concert can be set up, with some pieces borrowed from the deceased's favorites and others from a musical *doxa*. This is especially true of European cremation rituals, where pop music or rock pieces can be heard, along with popular classical songs such as Albinoni's *Adagio* (that were at one time commonplace) or popular songs. The goal is again to celebrate not only the deceased's memory through his or her musical tastes but the community's concern with the individual's death and the meaning of the community's convening around the dead body. Music then brings remembrance of one of the most elementary meanings of "religion," which is to bring together.

When music is played at a particular ritual, the corpse of the deceased need not be present. Some remembrance services are often held long after the deceased's departure. Then music, especially sung music, is provided by the community or special members, such as monks, for example. Music is given the role of maintaining the memory of the dead as well as the continuation of the community. Its virtues of repetition, of reinforcing eulogies, of imposing silence to the listeners suit well the need of evoking and summoning the dead in order to protect the community against any threat of the dissolving time. This is the function of any ritual, at any level of human togetherness.

Claude Javeau

See also Depictions of Death in Art Form; Funerals and Funeralization in Cross-Cultural Perspective; Literary Depictions of Death; Popular Culture and Images of Death

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Funeral Pyre

A funeral pyre is a wooden structure built over a fire and used in funeral rituals for the cremation of a corpse. The raised structure allows for air to flow underneath the flames, but it also allows for better viewing of the pyre in ceremonies attended by mourners. Outdoor cremations, a feature of aristocratic funerals in the ancient Near East, Carthage, Greece, and Rome, are no longer performed in the West but are still common in India.

Cremations were performed in the West in the Bronze and Iron ages alongside inhumations. Pyres and funeral biers are attested in ancient Greek and Latin literature, and depictions appear on Greek pottery from the archaic and classical periods. In Homer's *Iliad* Book 23, Patroklos is cremated on a pyre after the sacrifice of horses, dogs, hostages, and the placement of gifts and armor. The live cremation of Croesus, King of Lydia, on a pyre in Herodotus's *Histories* (Book 1) is interrupted by rain and serves as a cautionary tale on divine retribution. In Greek mythology, the hero Herakles was cremated as a vehicle for his apotheosis (see Euripides' *Herakles*). Following Homer's lead of incorporating cremations within epic narratives, the cremation of warriors on pyres, following a battle, became part of the funeral and burial trope in Latin epic poetry. The individual and mass cremations of warriors are found in the epics of Ennius, Vergil, Ovid, Lucan, Valerius Flaccus, Statius, and Silius Italicus.

In ancient Rome, cremations and inhumation burials were performed contemporaneously. The archeological and historical evidence for cremations is extensive. For cremations that took place where the deceased would be buried, a corpse was placed on a bier (*feretrum*) or pyre (*rogus*) and after the cremation, the place of cremation was covered with solid to make a mound (*bustum*), which could be covered by a funeral monument. To mark the spot where Julius Caesar was cremated, however, a temple was built in the Roman Forum that signified his apotheosis. If the cremated remains were to be stored elsewhere, the ashes and bone fragments were collected and placed in an urn, normally with a finger of the deceased, which was removed before cremation. The urn could be deposited in mausoleums, family tombs, funeral monuments themselves, including sarcophagi, or in burial niches (*columbaria*), all of which were located outside the urban center of Rome (marked by the religious boundary that encircled the city called the *pomerium*) until the Imperial period when the cremated remains of Trajan were deposited in a column (dedicated in 113 C.E.) that still stands in his forum. Due to the amount of wood needed to sustain an appropriate temperature for cremation over several days, the ceremony was expensive and time-consuming, even for modest cremations. Interruptions due to inclement weather were common, and the ceremony would be resumed once the weather improved.

Pyres were associated with the Roman Imperial funerary ritual (from the 1st to the 3rd centuries C.E.). The corpse of the emperor Augustus was attended by his wife Livia as it burned on a pyre for several days. As rituals associated with the cult of the emperor increased, the corpses or wax images of later Roman emperors were cremated on pyres as a vehicle for their apotheosis. A wax image of the emperor Pertinax, for example, was placed inside the second level of a multitiered pyre (*ustrinum*), with doors and windows on the upper level, that was decorated with marble, gold, statues, tapestries, and paintings and was topped with an image of the emperor in a golden chariot. During the cremation, a bird was released to signify the emperor's apotheosis.

The early Christian church established a doctrinal preference for inhumation burials over pagan cremations because of resurrection of the body which contained the Holy Spirit. The growth of inhumation burials in catacombs points to the need to avoid Imperial attention prior to Constantine's conversion, but it also indicates the decline of cremations except for members of the pagan elite who still practiced cremations. The long-standing Christian practice of inhumation led to the decline of cremations in western and eastern Europe until their revival among Protestant denominations in 19th-century Britain and the United States in indoor crematoria. The Catholic ban against cremations was lifted in 1963, but ashes must be buried in a cemetery. Originally fueled by wood or coal, contemporary cremations are performed in furnaces fueled by natural gas or propane and regulated by codes that specify the height

of furnace chimney stacks and the distance between crematoria and residential areas. The body may be burned in a cardboard or combustible casket. The collected remains are called ashes or cremains.

Cremations on a pyre remain an important rite in many religions, including Hindu, Sikh, Jain, and Buddhist funeral ceremonies. Traditional Hindu cremations, for example, take place outdoors: After the ritual preparation of a corpse, the corpse is carried to a holy place and placed on a pyre that consists of sandalwood and palasa wood. The pyre may be a structure built on land or a platform that floats on water. The head of the corpse points north and is cooled by water to relieve the deceased from any agony. Following the cremation, bones and ashes are scattered in the Ganges or brought to areas sacred to ancestor worship. Orthodox and liberal practices vary: It is becoming increasingly common, especially in large urban centers, for a corpse to be cremated in a crematorium but for the ashes to receive death rituals at a holy place.

Mario Erasmo

See also Christian Beliefs and Traditions; Funerals; Hindu Beliefs and Traditions; Jewish Beliefs and Traditions

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Funerals

The funeral has long been a component of society's attempts to adjust to and cope with the loss of one of its members. Traditionally, it has served as a ceremony acknowledging death, as a religious rite, and as an occasion to reassure and reestablish the survivors' social group after death. The funeral serves to commemorate life as well as establish a ritual for disposal of the body. The funeral service itself serves at least two purposes: completing the final placement of remains (its secular function) and confirming public recognition of the deceased person's transition from life to death (its sacred function).

The funeral serves to make real the implications of death, and it assists in the individual, family, social, and spiritual integration of living after death. To the extent that funerals are typically short-lived events, such full integration via the funeral may not be possible in many cases. Grieving obviously goes on for some time after the funeral, and thus the funeral may help initiate, but not necessarily maintain, grief work.

The Evolving Funeral Ritual

The funeral in America has transitioned from a rite of passage, understood by the attendees as being for the benefit of the decedent, to what is primarily a social ritual, understood by attendees as primarily for the benefit of the bereaved. The work of Philippe Ariès, a French cultural historian, dealt with historical shifts in attitudes toward death, tracking funeral practices from the 18th to the mid-20th century.

In the era of sacred death, the 17th and 18th centuries, death was associated with the dying person taking leave of this world on the way to the next, and there was a clear distinction between the religious funeral (marking this metaphysical passage) and any civic event that might follow it. Over time, the religious and civic ceremonies began to merge, but the sacred significance remained inherent in the conception of the funeral.

During the era of secular death, beginning with the 19th century, urbanization brought about the specialization of death professionals, who were often nurses for body preparation and furniture dealers for casket provision and interment. This eventually gave way to the development of the mortician/funeral director occupation. Funerals during this era took on more secular functions, including wealth display and the fulfillment of expected social roles. Whereas the focus of the funeral in the era of sacred death was upon the deceased, funeral processes during the era of secular death focused on the bereaved.

Finally, the era of avoided death, from post–World War II to the present, is defined by modern

medicine's victories in the face of many diseases. Indeed, until this occurred, the frequency of untimely deaths undermined a person's ability to ignore the continuing possibility of encountering death in everyday existence. With life expectancy increasing, and with the growing professionalization of death care services, the vast majority of Americans could now live much of their lives as if death did not exist. This avoidant stance toward death is then played out in the funeral process, in which mourners maintain considerable distance from the ugly realities of death and decomposition.

These changes have coincided with a pluralistic shift in American society, in which individuals live, work, and socialize with others who do not necessarily share their religious/metaphysical beliefs and values. So, when someone dies, the community relevant to the death may represent many religions, many attitudes toward death, and many funeral customs derived from their respective families and subcultures of origin. This evolution has yielded a greater emphasis on the sociological function of the funeral ritual. Although the other functions continue to have impact, the social coming-together represented by the funeral and the direct expressions of social support for the primary mourners constitute a large portion of the funeral events.

Some have suggested that the multicultural context of American society—lacking a unifying and shared mythological framework—will lead (indeed, already is leading) to a "ritual-less" society. As it appears likely that American society will continue to evolve toward greater diversity of values and beliefs, such a prediction should be taken seriously, and its impact on the funeral ritual should be considered. However, since the attacks of September 11, 2001, American culture has shown a clear affinity toward ritualized social action geared toward memorialization of death. This trend was already beginning to emerge following the Oklahoma City bombing in 1995; the memorial park now open in that city might be understood as a continual funeral ritual. It is worth noting that this reemergence of mass-culture ritual has taken place without a corresponding homogenization of religious/metaphysical belief systems. Thus, it appears that societies can develop meaningful shared rituals that are based upon shared experiences rather than commonly held religious beliefs.

In this light, it should be no surprise that historical and individual variations exist with regard to how Americans view funeral processes. In addition, the funeral industry has been criticized as it has served (and perhaps directly influenced) these variations.

Some of these critics, for example, feel that American society has given control of the funeral to professional funeral directors, wherein such persons are now viewed as experts whose functions are to both stimulate and satisfy the needs of bereaved persons (e.g., by providing services that both reflect and stimulate demand) and to maintain the illusion that death represents both a painless state and the end of a fulfilling life. This may explain the desire to view the corpse as peaceful, where the funeral director's control over death is emphasized. Freed of the responsibility for preparing the body for viewing, individual consumers may feel license to be critical of those whose services they have purchased, further distancing them from the harshness of death. This distancing reflects the bureaucratization of death, and the ambivalence that many feel is embodied in the power that the funeral director enjoys in possessing the body, while his or her embalming "protects" the bereaved person from the realities of death. This power permits the funeral director to exert considerable control over the funeral ritual itself. The growth of the modern hospice movement, debates over the ethics and morality of euthanasia, and attention paid to the morality of physician-assisted suicide all reflect the dissatisfaction that persons feel in ceding control over the dying process to others, emphasizing the quality over the quantity of life in so doing.

Others are concerned about the dysfunctional nature of the funeral; its commercialistic and exploitive nature undermines its meaningfulness as a ritual to celebrate the life of a deceased loved one. As customers are ultimately at a disadvantage due to a lack of knowledge about what to do when someone dies, and due to the emotionally vulnerable state in which they make funeral decisions, they often make decisions that are hasty or in response to pressure from the funeral director. For these reasons, the funeral fails to meet the spiritual and interpersonal needs of the grieving family, often operating in a void with respect to its relationship to the community.

In light of such criticism, it is interesting to observe that many studies suggest that the public is, generally speaking, satisfied with the funeral ritual; there is a general belief that the funeral industry does a credible job in meeting their needs. Indeed, the vast majority of persons state that they are satisfied with the quality of funeral services they have received. Yet, only a minority indicate that those in the industry were helpful, compassionate, caring, and competent.

With regard to desired changes, the most frequently mentioned issue is, not surprisingly, cost (people spend an average of $4,000–$6,000 on a funeral). Indeed, the 1984 Federal Trade Commission Funeral Rule prevented funeral directors from quoting a single price for the overall funeral, requiring funeral homes to provide customers with an itemized list of charges and descriptions of available caskets, while asserting that funeral directors cannot prevent customers from purchasing a casket from someone other than the funeral director.

Attitudes Toward the American Funeral: Historical Variations

Little research has been conducted on the American funeral process, and much of the information that is available is several decades old. More recent evidence suggests that views of the funeral's relationship to death and grief have changed, leading to changes in both the American funeral and the ritual responses to death, which may make funerals more effective resources for coping with death and bereavement.

Regarding cohort shifts in funeral attitudes, a 1967 nationwide survey of funeral directors indicated that a funeral in America was perceived differently by different people. This is because a funeral does not take place in a vacuum, but rather is dependent on regional and cultural beliefs, customs, and attitudes. An overall cultural shift in beliefs and attitudes about death, dying, and bereavement would therefore necessarily affect attitudes toward funerals and assessments of their purpose. There is evidence that such shifts have indeed occurred, wherein over a 30-year period persons were more likely to have thought about such practices as organ donation, were more likely to feel "indifferent" about having their bodies embalmed, and were no more likely to have made funeral arrangements ahead of time. This suggests that over historical time, attitudes toward the traditional funeral ritual as a means of bodily disposal or affirmation of the life of the deceased person may have become somewhat more negative. Developments in health care technology, for example, could be interpreted as a reflection of a general reluctance to accept the inevitability of death and may reflect a lessening of the importance of the funeral's sacred role. Historical shifts in demographic factors such as mortality rates or persons' economic status could also influence variations in funeral attitudes.

Attitudes Toward Funerals: Individual Variations

There appear to be individual differences in attitudes toward funerals and funeral preferences, wherein nonreligiously affiliated persons tend to be more critical of the funeral process, and persons who are more highly educated and who have higher incomes tend to be most critical of funeral rites and ceremonies.

As people vary in age, they also vary in the likelihood of having attended a funeral. Prior experience, tradition, and general knowledge of funeral practices, then, impact one's expectations of a funeral ceremony. Cohort membership also affects one's expectations and attitudes toward funeral ceremonies and the processes involved in organizing them. Specifically, middle-aged and older persons tend to hold more favorable attitudes toward funerals and funeral directors, which may be due to young persons' often less traditional approach to dealing with grief as well as covarying with the number of funerals one has attended.

Attitudes toward funeral rituals also vary with religious, ethnic, and socioeconomic factors, such as the actual merchandise one purchases (e.g., the type of casket), the nature of the disposition of the body, and the funeral's overall cost. A family's means of absorbing such costs would likely affect its attitude and perception of the entire experience. Other influences on funeral attitudes include who oversees the final arrangements and the level of that person's prior knowledge of how to make such plans.

Intrusive problematic events can also influence or distort the funeral process and one's experience

of it. Family tension and discord, for example, add stress to an already difficult time for mourners. For example, a lack of consensus on matters such as deciding upon an open- versus closed-casket ceremony virtually guarantees someone will be dissatisfied with the service. Nonetheless, mourners who are able to find solace in the funeral cope better in the long run, even if the funeral was marred by one or more problems.

Gender may also be related to one's attitude toward funerals. For example, regarding funeral directors, the public often is more comfortable in dealing with women. Many of those making arrangements are widowers and may therefore prefer talking with female funeral directors. Studies suggest that men tend to be most concerned with the costs associated with the funeral, whereas women tend to be more concerned about the appearance of the body and with social relationships related to family and friends.

Persons' attitudes toward funerals are likely to be more positive when the funeral and director(s) can effectively aid in the venting of emotions and when they respond adequately to the psychological needs of the survivors. The question of funeral beneficence, then, is likely to covary with individual survivor characteristics and the circumstances surrounding the death. Specifically, a high-grief death, such as the unexpected death of a child, would greatly increase the chance of potential difficulties in psychological adjustment, while the death of an elderly relative, which is more likely to be an expected one, could result in less psychological harm to survivors. As involvement in funeral rituals may help the adjustment of such persons, the therapeutic effect of funerals may be the greatest when the death was traumatic, as in suicides, or in the case of sudden or violent deaths.

Some researchers have argued that funerals now better reflect the psychosocial needs of both the mourner and the community in which the mourner is embedded. Persons who vary in age also vary in the likelihood of having attended the funeral of a friend or family member, and on this basis alone, one might predict that there would be age differences in perceptions of the funeral. Likewise, persons who are members of different cohorts, who were born in different historical times more than likely have had different experiences with loss in the context of the funeral.

Age cohort differences in perceptions of funerals might also be important from a marketing perspective. Those who are bereaved or who have yet to lose a loved one will either be the direct recipients of funeral services (and consequently may express a preference for a particular type of ceremony in anticipation of their own eventual deaths), or will seek out such services in the event of the death of a friend or family member. Likewise, variations along ethnicity, gender, whether the survivor had experienced a sudden loss, whether the death was violent, or whether the deceased had died in a manner that might undermine the support available to the griever via the experience of disenfranchised grief all must be considered in understanding persons' orientations to the funeral and/or its benefits to individuals and to the community.

Outward symbolic manifestations of grief that are culturally determined (e.g., having flowers to symbolize the continued existence of someone who has died, being able to view the embalmed body in a casket, being part of the funeral procession to the burial site) may be rejected by younger adults in favor of cremation and/or a memorial service, organized not by the funeral director but by family, friends, or both. The latter expressions of grief may not only be less expensive, but may also give family and friends more control over what happens, when it happens, and what is said by whom than might be possible when the funeral director takes the initiative in structuring the funeral service, such as in suggesting a range of caskets, music, flowers, the location of the funeral, alternatives to a traditional service, or the burial site itself. One might also speculate that younger persons, who have had fewer losses with which to deal, are consequently less knowledgeable about the funeral industry. Simply learning about what it is that funerals and funeral directors do and do not do might mitigate such misperceptions.

Funerals of the Future

Given the complex, culturally embedded nature and function of death rituals, it is impossible to predict the exact direction of their continued development. Certainly, there is a growing movement toward funerals that are more personalized, as in the creation of a CD documenting the life of

the deceased, reflecting the funeral's sacred function. Likewise, a growing trend toward convenience is reflected in the "drive-thru" funeral, where mourners can pay their respects in the comfort and convenience of their car and view the embalmed corpse on a television screen, with an accompanying eulogy on the radio. Another variation reflecting the funeral's secular function, which might gain in popularity, involves a novel method of body disposal, wherein the body is submerged in liquid nitrogen coupled with ultrasound wave bombardment (to ensure thorough internal freezing), and then nearly all the liquid is removed from the remains via a vacuum process. The resulting remains consist of an odorless organic powder that can be safely dispersed onto soil with no toxic release. Other, perhaps less extreme possibilities for body disposal and funeral rituals involve cremation and memorial services, respectively. Much like the evolutionary survival of specific consumer electronics, the particular trends that survive and become accepted standards will likely have much to do with effective marketing and happenstance rather than functional superiority, reflecting a greater awareness of mourners' needs and preferences when a loved one dies.

Bert Hayslip Jr., Melissa L. Ward, and Kenneth W. Sewell

See also Bereavement, Grief, and Mourning; Body Disposition; Caskets and the Casket Industry; Cremation; Funerals and Funeralization in Major Religious Traditions

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Funerals, Military

Military funerals are funerals for any veteran other than those individuals who left the military with less than an honorable discharge, for soldiers who died on the battlefield, and for other well-known military figures. Customarily, when the president or prime minister or monarch of a nation dies, he or she receives a military funeral. The funeral ceremonies vary based on the rank of the deceased, with the highest honors going to general officers and high-ranking civilians who supervise the armed forces, such as the secretary of defense or heads of state.

History of Military Funerals and Rituals

While military funerals have been provided for soldiers probably back to the times of the Greek and Roman empires, the military funeral, as it is practiced in the United States, draws its basic elements from the French and British military funerals of the 18th and 19th centuries. For example, the practice of draping the casket with a flag began during the Napoleonic Wars in Europe (1796–1815). The firing of rifles over the gravesite began as a practice of firing rifle volleys during the 18th and 19th centuries that were intended to announce that each side had cleared its dead from the battlefield.

The common practice was to fire three volleys to verify that the clearing of bodies was complete.

The 21-Gun Salute

The 21-gun salute, reserved for those receiving the highest honors, has a more complicated history. Initially, salutes of any kind, such as the hand-to-forehead salute as practiced in most militaries around the world, simply indicated that the one offering the salute placed himself or herself in a position of being unarmed. But gunfire salutes have been used since guns were first used in battle. Gun salutes were fired as a manner of greeting from one contingent of soldiers to another. Historically the British insisted that the first salute be fired by the "weaker" country. However, with the rise of the notion of equality of nations, the international practice became one of a gun-for-gun salute.

The British had actually begun the official gun salute based on the use of seven guns. Over time, the British salute evolved from 7 guns to using 21 guns. In the United States, the practice was to fire one gun as representing each state in the Union. With growth of the Union, by 1818, the salute had reached the use of 21 guns. This number continued to grow but, in 1841, the United States reduced its formal salute to 21 guns. But there remained a great deal of confusion in various American states concerning how many guns were to be used. The United States adopted a British suggestion that America join the practice of most nations in officially recognizing 21 guns as the international salute. On August 17, 1875, the United States adopted the 21-gun salute and the practice of "gun for gun" in the salute. From that time on, the 21-gun salute was a high honor at military funerals reserved for those of very high rank.

"Taps"

Another feature of American military funerals is the playing of "Taps" by a bugler. Before 1862, the official call at the end of the day (or at the end of a soldier's life) was "Tattoo," also known as "Lights out." "Taps" was written by Brigadier General Daniel Butterfield at the end of a horrendous day during the Civil War. He wrote out the melody while he was wounded. The piece was meant as a tribute to the 600 men he had lost from his brigade that day. Although the tune was written by a general in the Union Army, by the end of 1862, the call was used by both Union and Confederate troops. "Taps" was officially adopted by the United States Army in 1874. It became known as "Taps" because if a bugler was not available at the end of day, the melody was tapped out by a drummer. The sounding of "Taps" at military funerals began in 1862, the same year it was written. The haunting, reverential melody seems especially appropriate to recognize the end of soldiers' lives, the end of their days on earth.

Standard Military Funeral

At this time, a standard military funeral includes the services of a military chaplain, a casket team (at least two active members of the armed services—this includes the Reserves and the National Guard as their members may be tasked with funeral detail), a firing party, a bugler or electronic recording of "Taps," and a flag to drape the coffin. Provided by the Department of Veterans Affairs, the flag will be folded in an honors ceremony and presented to the next of kin at the gravesite. For officers and warrant officers, the casket team will be replaced by a casket platoon and a military band may be provided. For some officers, especially those of high rank, the casket may be placed on a horse-drawn caisson. When the burial is of a colonel or higher rank, or a former president or secretary of defense, a riderless horse may accompany the caisson. The riderless horse represents a fallen leader. There may also be a 21-gun salute for a president or former president.

At the funeral ceremony, the coffin is draped in a U.S. flag. At the gravesite, the rifle volley is fired (in the case of a member of the U.S. Navy, a cannon may be used), and "Taps," with the bugler placed some 30 to 50 yards away, is played. At present there is a paucity of buglers who are enlisted in the armed forces and, as a result, a recording of "Taps" is now played at many military funerals.

At the end of the military ceremony, the flag is folded in the military manner and is presented to the next of kin. When presenting the flag, the member of the funeral detail states, "As a representative of the United States Army [or Air Force, Marine Corps, or Navy], it is my high privilege to present you this flag. Let it be a symbol of the

grateful appreciation this nation feels for the distinguished service rendered to our country and our flag by your loved one." Although all funerals are a way for family members and friends to say a formal and dignified good-bye to the deceased, the additional honors of a military funeral make this a most solemn occasion.

Kathleen Campbell

See also Funeral Music; Funerals; Tomb of the Unknowns; War Deaths

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Funerals, State

A state funeral is a public event held in honor of a figure of national significance—most commonly heads of state. There is no legal requirement for a funeral, as burial or cremation can be arranged without any service or congregation, but the continuing popularity of the ceremony is testament to its efficacy as a ritual focus.

The funeral is a liminal event; a rite of passage with coded behavior experienced outside of routine and in the realm of social transition. The immediate nature of rites of passage, and their concrete expression of ephemeral reality, serve as a vehicle for heightened emotions. Although mourning varies from culture to culture, common elements of the ritual practice are (a) the expression of community, (b) the reestablishing of social order, and (c) public expression of private grief.

The Expression of Community

State funerals, due to their civic dimension, enact social transition beyond the private grief of bereaved family and friends. As political rituals, state funerals serve as evidence of value integration, an expression of integration, a mechanism of integration, and a means to constitute integration.

There are a range of performance elements within state funerals, including lying in state, the funeral procession, the funeral service, and the burial, all of which can be used to signal particular cultural values. It is possible to view the state funeral as a performance-based expression of social belief. As such, state funerals are "theaters of power" that function as an occasion to mythologize an individual in a manner that serves the social group.

Mourning rituals of ancient Rome demonstrate the mythologizing of the individual within the context of the community. The accomplishments of the deceased were celebrated with those ancestors. Often elaborate funeral processions took place with hired mourners and a funeral oration that served to publicly reaffirm shared cultural values. The Roman funeral celebrated loyal service in public office and can be seen to honor both the individual and the authority of the state. Katherine Veredery identifies the continuing politicization of the dead body, suggesting that contemporary nation-states also use a funeral event as an opportunity to review national history through the lens of an individual life.

The founders of the United States initially avoided the pageantry of state funerals due to the resonances with British rule. Although William Henry Harrison was the first American president to die in office, Abraham Lincoln's funeral in 1865 is observed as a seminal ceremony, as technology allowed the news to spread quickly across the country, encouraging national, collective mourning. Lincoln was not a popular president, but his death occasioned the rehabilitation of his reputation.

Funerals are powerful rites of reconciliation that may dispel controversy and promote a sense of public accord. In death, Lincoln represented a martyr, and his assassination was seen as an attack on the American people. It is noteworthy that the grandeur of Lincoln's funeral represented an attempt to use the occasion as a restatement of American values. The organizers sought to reach

out to as wide an audience as possible and allow for a sense of catharsis through engaging the drama of the funeral rite. Lincoln actually had a number of funerals. His body travelled via a funeral train that stopped in 12 cities where the body lay in state, as well as passing through many more where people gathered on station platforms to mark his passing. A number of local ceremonies took place along the route, with community members constructing their own memorials. Thus, Lincoln's funeral is an example of a state-orchestrated event that was used to mediate between local and federal authorities.

Sensitivity to the need for communal catharsis was displayed during the funeral of Mahatma Gandhi in 1948. The Hindu tradition is to cremate those who die and scatter their ashes in rivers or the sea after 13 days. However, the government decreed that Gandhi should be given a state funeral which, despite the swift arrangements, was a large-scale event. Gandhi's ashes were then sent to towns and villages across India so that local communities could mourn the leader. This set up an unusual dynamic as not all the ashes were returned. Indeed, some of the urns were held by the public in bank vaults—a striking example of the commodification of the dead body.

Reestablishing Social Order

The bringing together of community around the funeral event allows for a reestablishment of public order, which authorities may use for their own ends. The Medici dynasty (13th–17th centuries), for example, made use of funeral services to consolidate their political power during the Renaissance. The Medici *Esequie* were based, in part, on an ancient Roman ceremony, with particular attention to staging and audiovisual effects. Much use was made of candles, due to the positive associations of light and flame developing from ancient Rome. Unlike the Roman ceremonies, the Medici rites incorporated the Christian belief in an afterlife, although the Esequie was not a purely religious ceremony. Like many contemporary state funerals, it blended the spiritual and the secular, traditional and contemporary in order to maximize its impact. The Esequie was a political statement that focused on the golden age of Medici rule in order to consolidate their authority as ruling elite.

Admiral Nelson's funeral is a British example of a power struggle contained within the ritual structure of a state funeral. Nelson died on October 21, 1805, while on board HMS *Victory*. The decision was made to break with tradition and not bury him at sea but to preserve his body and take it home to honor with a state funeral—a rare event for someone not of royal blood. Considerable planning went into the 5-day funeral celebration held in January 1806, yet Admiral Nelson's popularity was perceived as a threat to the monarchy, and the King's allowance of a state funeral may be seen as an attempt to win over the masses. Nelson's funeral, like the Medici events, was a performance influenced by the theatrical conventions of the day, and its staging served the political agenda.

Instead of a family member, the admiral of the fleet was appointed as chief mourner, which may have been an attempt to promote the idea that the British Navy was the heir to Nelson's legacy. The organizers were sensitive to the desires of the populace and, due to public pressure, a decision was made to include sailors from the *Victory*. The funeral plans were also modified to fulfill the public desire to view the body of Nelson as it was transported through the streets. Public witnessing is a key element of the state funeral and can be understood in terms of the psychological drive to look upon death and with the ritual object of the coffin as a focus for collective community grief.

Nelson's coffin was decorated to celebrate his life and victories and was theatrically framed during his lying in state by trophies, candles, and six mourners. The mourners were arranged in a manner deemed to be appropriately somber to act as models for public behavior, as the authorities were concerned about rioting because the death of popular heroes can be a trigger for public unrest. The funeral procession was also designed as spectacle with a funeral car that represented the *Victory*, modeled on the pasteboard ships used in the contemporary theaters. The theatrical element was highlighted by the fact that tickets could be bought for seats in the stands that lined the route. There was also raked seating for the funeral service at St. Paul's Cathedral, which was artificially lit to ensure the audience had a good view of the ceremony.

Public Expression of Private Grief

The state funeral also can provide a framework for the public expression of grief. The motto for the authorities dealing with the funeral of Mao Zedong (Mao Tse-tung) was "from grief into strength," and people were urged to take the opportunity to pledge themselves to continuing the cause of the leader. During his lifetime Mao had proposed that he should be cremated in order to avoid superstition and ritual but, in death, his body was claimed by the Communist Party and shaped by the politics of legitimation. The first announcement following the death of Mao was a statement reiterating Communist policies. This was followed by information about arrangements for the mourning services—to which no foreign dignitaries were invited. Following a period of lying in state, a memorial rally was held and broadcast throughout China as people all over the nation stood at attention for 3 minutes of silence. There was an outpouring of grief—which some critics argue was a result of people not being able to mourn their own families during the Cultural Revolution—and the authorities sought to channel this emotion into oath-taking ceremonies in which people pledged continuing allegiance to the Party. After the mourning services, Mao's body was housed in a memorial hall that commemorated his contributions to revolutionary history.

Reference to tradition is an important element of a state funeral and, when planning her husband's funeral, Jackie Kennedy sought to duplicate elements of Lincoln's funeral in a manner that suggests an understanding of the potency of linking to icons of power. There were, however, considerable differences in the funerals of the two presidents, as a result of modern technology. In the 1960s the mass media allowed for millions of people all over the world to witness the funeral of U.S. President John F. Kennedy. Television also offered continuous coverage of developments that could meet the desire to witness, but also, as Harry Garlick suggests, could act as an "intensifier" to accelerate the movement from shock, through grief, to the resumption of normal social life. Victor Turner states that ritual serves an important social function in terms of reintegration and that Kennedy's funeral offered a ritual closure to the distress following his murder. The presence of the television cameras allowed for intimate gestures to be captured, for example, John Kennedy Jr.'s salute to his father that was held to communicate traditional American family values. The television coverage may have created a false representation of events in that it framed particular elements at the expense of others and presented a more polished appearance than actuality.

Takashi Fujitani goes so far as to describe the funeral of the Showa Emperor in Japan in 1989 as a ritual made for television. All Japanese were encouraged to mourn appropriately. As with many state funerals, the government declared a national holiday. Shopping centers and businesses closed, and 10,000 people, including international dignitaries, attended the 2 hours of religious and state funeral rites; many more watched the ubiquitous television coverage.

The funeral of Diana, Princess of Wales, in 1997 was also a large-scale media event, but it functioned in a different manner to the Japanese state-sanctioned mourning process. The media influence began with the articulation of public dissatisfaction with the initial state response to Diana's death and the plans for her funeral. As in the case of Nelson, plans were adapted in order to meet popular desires, with the result that the Princess was honored with, in all but name, a state funeral. A martial atmosphere was avoided and representatives of significant charities were included in the funeral procession. This can be seen to have the same populist intent as the Mexican state funerals of the 1880s that included groups of workers in a manner that was designed articulate democratic principles. As "the people's princess," Diana was mourned by representatives from the community who reflected her humanitarian values. The democratic intent was also demonstrated by the erection of large television screens that allowed the public gathered outside Westminster Abbey to follow the ceremony.

It seemed, however, that merely witnessing events was not enough to hold the public's outpouring of grief, and Susanne Greenhalgh discusses the "spontaneous shrines" of flowers, photographs, and candles placed at public sites—particularly the palaces in London. These can be seen as an expression of the tension between the official ceremonies and the desire to enact personal rituals as a means to perform private grief in public.

The death of a public figure may evoke heightened emotion. Through association, people may

become aware of their own mortality, and the death may serve as a locus for unresolved private pain. Richard Huntington and Peter Metcalfe argue that the death of a royal figure symbolizes the deaths of all the people. The state funeral is therefore a powerful container for public sentiment. It is also, at the same time, a potential tool for the ruling elite to establish or confirm their authority, as the death of a key figure may signal the transference of power. The state funeral thus negotiates both public and private realms and seeks to frame transitions within the staging of a ritual practice.

Emma Brodzinski

See also Commodification of Death; Communal Bereavement; Depictions of Death in Television and the Movies; Funerals; Funerals, Military; Spontaneous Shrines

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Funerals and Funeralization in Cross-Cultural Perspective

This entry deals with funerals and funeralization across the multitude of world cultures. Thus, a definition of funeral that is respectful of cross-cultural variation includes the death rituals engaged in to deal with a corpse plus all the rituals that deal with the spiritual, property, role changes, and other matters connected to the death. Death rituals are all the rites, ceremonies, celebrations, and other culturally recognized and commonly performed activities that are carried out as the result of a death. Funeralization is defined as the action, process, or result of carrying out a funeral.

One cannot understand what death means in a culture or how the survivors cope with the emotional, relationship, economic, spiritual, and other consequences of a death without understanding funerals in that culture. There are enormous variations in funerals from culture to culture, but there are also similarities. The variations and the similarities together illuminate human plasticity in dealing with death and also what is basically human.

The enormous differences across cultures in rituals surrounding death indicate that one should be careful in applying a conventional English language definition of the term *funeral* to death rituals across cultures. If one defines a funeral following conventional English language usage as the rituals engaged in shortly after a death to dispose of the dead body through burial, one would miss that in many cultures the rituals may be carried out over months or even years and that body disposal does not necessarily involve burial. Indeed, the death rituals of many cultures will seem foreign to those in the United States who are accustomed to conventional U.S. funerals. For example, in many cultures funerals can include ritualized wailing, self-mutilation, shaving the heads of bereaved individuals, investigating who performed the witchcraft that killed the deceased, animal sacrifice, ritual obscenity, destroying the property of the deceased, or fleeing from the corpse. What might seem bizarre makes sense once one understands the relevant cultural meanings. Within the meaning systems of a culture, how people deal with a death makes sense to them and is valued by them.

All known cultures have funeral rituals, practices that are preferred, that are typically engaged in, that have meaning and give meaning. Bodies are not just abandoned. A death must be dealt with. And this says something about our common humanity. Death is not trivial. Corpses are dealt with in meaningful ways. Funeral rituals give

meaning to the life and death of the deceased, to life and death in general, and to the reactions of the survivors. Funeral rituals are social events and so they define social relationships, enact and reinforce social norms, and often strengthen social relationships.

In many cultures, funeral rituals are spread over months or years, with an initial set of rituals and an initial disposal of the remains of the deceased shortly after the death. Eventually there is a final funeral ceremony, months or years after the death, which usually ends formal mourning, and often at the final ceremony there is a final disposal of the remains of the deceased.

Social Science and Indigenous Understandings of Funerals

There are many social science theories that explain and illuminate funerals. These theories can help us to understand, for example, why it is that people in some cultures destroy the personal property of the deceased or carry out funeral rituals that extend over several years. Looking at a culture from the outside may point to underlying processes, connections among different aspects of the culture, and lines of thought that make sensible and relatively simple what otherwise would be, for the outsider, a disconnected hodgepodge.

Social science explanations are often, however, out of touch with the cultural realities of the people engaging in their culturally meaningful funeral rituals. People are likely to have their own cultural reasons and explanations for what is going on and what they do. To ignore these because one is relying on a social science rooted in one's own culture for understanding could be seen as ethnocentric or culturally rude, and it also may rob one of genuine understanding of relevant realities of the people in that other culture. For example, one may use social science theories to look at a culture's death rituals as involving rites of passage from one set of statuses and roles to another, as involving breaking ties with the deceased or recruiting grief support, or as giving meaning to the death and the life of the deceased and to people's feelings of grief. But the realities of people in that culture may concern respecting and caring for the spirit of the deceased, healing a breach in kingroup connections, and carrying out proper kinship obligations. Thus, genuine cultural sensitivity requires one to understand that social science theories typically come from an outsider's culture and that to understand the experiences and realities of the people from a culture in their own terms, one must grasp the meanings they give to events.

Cultures Are Internally Diverse

It is a mistake to assume that people who share cultural origins carry out death rituals in the same way. Death rituals in any culture are likely to be diverse, depending on the status, age, and gender of the deceased, the apparent cause of death, the wealth of the family and community of the deceased, the religion of the deceased and of the closest survivors, the occupation of the deceased, and much more. Such variations make sense in the meaning system of a culture that has the variations. But many cultures are also divided into subcultures, and the funeral rituals and meanings given to these rituals may be quite different from one subculture to another. The subcultures may exist because different populations in the society have different cultural origins, have had different contact with other cultures, have different religions, or have responded differently to a national government that tried to impose new cultural practices and meanings. The products of this cultural complexity are, in some families and communities, cultural practices and meanings that blend several cultures but also are uniquely different from what is in any of the cultures from which the practices and meanings are drawn. The product could be that at funeral rituals there are tensions among family members about what is proper or that different groups in a community observe somewhat or even radically different rituals.

Not infrequently, a culture's complexity and diversity concerning funeral rituals are played out during the funeral rituals. In a sense, in some cultures part of the funeral rituals is contention or what should be done. And the contention also then shows up in judgments made by participants and onlookers who hold different cultural standards regarding the funeral rituals. They may, for example, differ on how much attention, support, and resources should be given to a bereaved spouse and how much should be given to the extended family or the community. They may differ in how to

protect survivors from the wrath of the spirit of the deceased, or whether such wrath is a possibility. They may differ in whether the fate of the spirit of the deceased is at stake and, if so, how best to help that spirit to a good future. These are not abstract and academic issues but often issues of enormous importance and emotionally intense feelings. But then it is also possible that people will come to accept their differences and even hold one another to different standards depending on the cultural allegiances of the deceased or of those who are most bereaved.

Cultural Diversity Within the United States

Often people who write about funerals in the United States write as though there is a single culture or, at most, a few cultures in the country. But the reality is that to understand funeral rituals in the United States, one must be open to the enormous variation among the several thousand different cultures present there.

Many people in the United States ignore the cultural diversity in death rituals around them. They may be intolerant and insensitive in ways that make it difficult for people from a variety of cultures to carry out their rituals. In fact, local laws may even block people from doing what they feel they must do to deal properly with a death. For example, Ann Fadiman reported that some Hmong immigrants from Southeast Asia who carried out funerals that included loud chanting for several days and also animal sacrifice found that local U.S. laws blocked them from engaging in their rituals. Laws that block funeral rituals can create dire personal, family, and spiritual problems for the bereaved, the community, and the spirit of the deceased.

Another problem that can arise from U.S. diversity in funeral rituals stems from the fact that some couples and families are bicultural or multicultural. People in such couples and families may get along in many ways, but their differences may come to the fore when someone dies. Culturally based funeral rituals are often difficult to compromise, because they are linked to very strong feelings and may have intensely important meanings concerning such matters as the fate of the soul of the deceased, the spiritual well-being of the survivors, and the family's place in a cultural community. Particularly the first times a bicultural or multicultural couple or family must carry out funerals might be especially challenging. For example, there are difficulties in some couples in which one partner is Jewish and the other is not. Many observant Jews believe strongly in not carrying out an autopsy, not embalming, and burying the deceased on the day of the death. A non-Jewish partner might believe, along with a large number of people in the United States, that an autopsy will help in coping with the death by providing understanding of what happened and that it is desirable that the body be embalmed and the funeral delayed a few days until out of town relatives can come.

When Appropriate Death Rituals Cannot Be Performed

Sometimes people are blocked from carrying out culturally proper death rituals because of war, natural disaster, or the nature of the death. It may not be safe to carry out the rituals, the body (or the entire body) may not have been found, or the ingredients or personnel for the proper rituals might be unavailable. Sometimes it is not known whether a person has died. Failure to carry out the appropriate rituals can add to the burden of grief, can block moving forward with some sort of closure, and may have dire cultural meanings, for example, that the soul of the deceased cannot go to heaven or that the spirit of the deceased will torment the living. To illustrate, in Rwanda in the 1990s, hundreds of thousands of Tutsi people were murdered in a wave of genocidal violence. As Deogratias Bagilishya wrote, the deaths of so many people who might have carried out death rituals for others who were killed, and the flight of many of the survivors, meant that death rituals were typically not carried out. In Tutsi beliefs, this means that great misfortune will occur to surviving family members. So in addition to the burdens of grieving many deaths, mass murder, and the loss of a way of life, Tutsis also have to contend with fear of possible consequences of not carrying out the proper death rituals.

Economics of Funerals Cross-Culturally

Across cultures, death rituals are often relatively costly. They may, for example, involve high costs for feeding visitors, paying ritual specialists,

providing proper clothing for the deceased and certain mourners, giving up income during an extended mourning period, or destroying the house in which the deceased died. Sometimes people cannot afford the proper rituals. For example, Paul C. Rosenblatt and Busisiwe Nkosi reported that among South African Zulus, many of whom are impoverished, widows are typically required to carry out a funeral ritual and a year-long *ukuzila* mourning ritual, and carrying out these rituals properly involves substantial expense. But many widows are very poor, and their neighbors, in-laws, and others in their social world may be just as poor, with nobody having enough to eat or proper housing, let alone money to support the expenses of funeral rituals. So the rituals may be carried out but not at the most desirable level, and the grief of some widows is complicated by their feelings about their poverty as well as by their feelings concerning their husband's death.

Funeral Rituals Change

Much can happen to change funeral rituals in a culture. In fact, it is difficult to find a culture of which one can say that the funeral rituals have been the same for generations. People immigrate to other parts of the world and lack the cultural supports to carry out the rituals that used to be carried out. Cultures change, for example, in gender roles, ideas of health and illness, religious beliefs, technology, residence patterns, and economics. People may intermarry with those of other cultures. A great epidemic like that of HIV/AIDS produces so many deaths that many who would have carried out the traditional rituals are gone and the financial and time resources for carrying out the rituals are not available. The changes do not come easily. Some people resist them. Some who enact the changes do not feel good about what they are doing. They may, for example, fear bad luck, feel guilty, or fear for the soul of the deceased. The changes may be seen as temporary or the best they can do given the circumstances, but even in those cases the changes will make great difficulty for people.

It was less than a century ago that bereaved people in many cultures in the United States stopped wearing mourning clothing and stopped observing a formal mourning period. The reduction in funeral rituals and public observance of mourning freed many people from heavy expense, from engaging in activities that did not fit how they felt, and from limiting what was proper for them to do at the workplace or in the community and family. But the de-ritualization of society's approach to dealing with death left some bereaved people at sea about what to, lacking in community and family support, and not helped along the path by funeral rituals that drew them through the grieving process and offered answers to important questions arising from the death.

Funeralization Outside the United States

In many cultures there is nothing like a funeral industry. Families and communities are on their own in funeralization, in carrying out their own death rituals. But in a number of societies, funeral industries have developed. In many of those societies, commercialized funerals are carried out only for some deaths. For example, reflecting wealth differences in other areas of society, the families who have commercial funerals are usually relatively well off.

The differences between U.S. funeral industries and funeral industries in other societies are instructive. For example, Hikaru Suzuki described how funeralization in Japan has, in the past half century, become increasingly commercialized. The shift to commercial rituals marks a shift away from fear of death and malevolent spirits, fear of decomposing remains, the need to move the spirit of the dead to the other world, and the need to strengthen internal family ties and also the family's ties with the community. With commercial rituals, there is little concern about impurity of the body and there is less sense of community connection. Now families focus on paying funeral specialists rather than on issues of danger and relationship. Whereas the community and family funerals of the past reinforced cultural values concerning social relationships and spiritual matters, contemporary funerals reinforce cultural values concerning economic transactions and reliance on paid experts. Commercial funerals in Japan are still culturally quite Japanese. For example, during the funeral service the corpse is treated as a living body, most bodies are subsequently cremated, and after that there is a 7-day memorial service. But the shift to commercial funerals still has brought substantial change.

In modern Hong Kong, to take another example, much of the traditional sequence of rituals and many of the traditional mourning practices have been curtailed, and there are more or less commercialized processes available to lead families through their funeral rituals. But that does not mean that Hong Kong funeral rituals are much like commercial funeral rituals common in the United States. Daoist, Buddhist, Confucian, or even Chinese Christian funerals still have central Chinese cultural elements and meanings. Commercialization brings common elements to funerals around the world, but it does not erase the very substantial variations across cultures.

Paul C. Rosenblatt

See also Death, Anthropological Perspectives; Mortuary Rites; Social Functions of Death, Cross-Cultural Perspectives

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Funerals and Funeralization in Major Religious Traditions

A funeral is a service marking a person's death. It is highly idiosyncratic, involving diverse customs, social statuses, beliefs, and practices used by religions or cultures to remember the dead. Funerals, derived from the Latin *funus*, are social and commercial events. Funerals involve an array of services as part of the process of paying final tribute to the dead.

Funeralization involves planning, implementing, and directing a funeral and burial according to the social, psychological, and religious needs of the deceased. The last step of funeralization is monument selection. Rituals, customs, prayers, eulogies, and often elaborate grave markers are employed to honor the dead. Historically, final tributes to the dead are found at ancient Neanderthal gravesites in France, India's mausoleum the Taj Mahal (an emperor's 1648 grief-stricken tribute to his dead wife), and Italy's famous 1469 relic of Saint Catherine's head preserved on a marble altar at the Chapel of Saint Catherine of Siena.

Along with industrialization, the increasing secularization and commercialization have changed the funeralization process. In America, this change evolved from simple burials to elaborate commercialization of death involving mummification, high-cost casket and vault display rooms, and a variety of buying options. Being funeralized is important in black American culture, with poor families spending more time and money than other ethnic groups on the dead. Throughout history there have been significant changes in funeralization leading to interesting and diverse practices.

Bahá'í Funerals

The Bahá'í faith is the newest world religion. A Bahá'í is a follower of the 19th-century "Manifestation of God" named Bahá'u'lláh, whose writings outline the Bahá'í teachings on death, burial, and afterlife. Known for its simplicity and dignity, the Bahá'í faith avoids funeral customs and rituals associated with older religions. Elected local spiritual assemblies (nine people) assist families with weddings, funerals, and other community

business. Bahá'u'lláh said death is a joyous event, a gateway to an afterlife. Heaven and hell are conceptualized as spiritual conditions, a continuum of varying degrees of closeness (heaven) and remoteness (hell) to God.

The deceased should be wrapped in five silk or cotton sheets; a single sheet of either fabric is sufficient for those from less affluent families. A Bahá'í burial kit contains 9 yards of very soft fabric (e.g., 100% natural silk or 100% pure cotton) cut into five pieces, the Bahá'í burial and the Bahá'í funeral service booklet, a small bottle of rose water, and a Bahá'í burial ring (with the inscription "I came forth from God and return unto Him, detached from all save Him, holding fast to His name, the Merciful, the Compassionate") placed on the deceased's finger.

The Bahá'í faith tries to avoid commercialized and materialistic funerals or memorial services. First, the burial ring is placed upon the dead person's body, which should not be transported more than 1 hour's journey from the place of death. Second, cremation or embalming is not permitted. Bodies should be treated with dignity and buried simply or donated to science. Third, funerals are absent of rituals or clergy, and typically are simple events. Funerals consist of the reading of prayers and other material pertaining to death and the afterlife from Bahá'í scripture. Services involve singing, music, and a eulogy. The only requirement is that the "Prayer for the Dead" (revealed by Bahá'u'lláh) be read by one believer. Prayers and readings are usually said at gravesite services. Bahá'í grave markers have nine-pointed stars or rosettes (the number nine is associated in the Arabic language with the name Bahá'u'lláh) with the word Bahá'í in the center and all other wording as desired.

Buddhist Funerals

Buddha's life, miracles, and death parallels those of Jesus. His "last supper" was an unintentional food poisoning by a blacksmith. Although Buddha knew of the mushroom, he suffered unperturbed as an example to all. When He wanted water from a nearby muddy stream, the water miraculously became instantly clear. He instructed a disciple to take refuge in the "Triple Gems" of wisdom, by saying: "I take refuge in Buddha," "I take refuge in His teachings," and "I take refuge in the Buddhist community." He advised a disciple to tell the blacksmith not to feel remorse and that there were two important meals: the one before Enlightenment and the one before Death. Buddha told his last disciple to work diligently for spiritual liberation in the material world. When Buddha died, His body was cremated, following the Indian custom.

Although Buddhist funerals vary depending upon the culture, there usually is a protocol surrounding funeralization. While the social status and resources of the family of the deceased have a bearing on the final arrangements, rigid protocols dictate funeralization. Wakes last several days with an open casket and an altar *butsudan* set up with flowers, fruits, a bowl of water, incense, and a candle. Buddhists chant for an hour or so prior to services. Then a procession of significant others line up on both sides of the room and place a pinch of the ashes into a bowl as each person offers a prayer for the dead person. After all view the deceased, the priest signals with a gong for the funeral to begin. After prayers, the priest and others offer eulogies. The service ends with a family member offering acknowledgments to attendees. Following tradition, the majority of services are cremations.

The funeral is usually held on the day after the wake. The body is transferred to a temple and placed before the altar. Modern Buddhist funerals are diverse, but the services tend to be highly symbolic, ritualistic, culture specific, and elaborate. However, the chanting and priest offering, originating in Japan, remain unchanged.

Japanese families go to the crematorium and are given a set of chopsticks to pick up the bones. Two relatives, holding the same bone fragment together and putting it into the urn together, place the important Adam's apple.

Often Japanese will place some bones in a temple, while others go in the family grave. The urn may be taken home or to the cemetery and kept there until after the 49th day memorial service. There are large differences in knick-knacks, floral arrangements, and the processions depending upon localities. After the cremation and bringing the urn home or placing it in the grave (Japanese family graves have a hollow space inside the gravestone to put the urns of the family), there are memorial services as well as prescribed times for gravesite

visitations. After the 49th day service, the 1st year Festival of the Dead service is often considered important, and memorial services are held in the 1st, 3rd, 5th, 7th, and 13th years and in other years, depending on the sect, up to the 50th year.

Christian Funerals

Unlike most Protestant funerals, Catholic funerals are elaborate rituals. Typically, Catholic wakes are held at the funeral home. People pay their respects to the deceased, offer private prayers, and participate in a short service with a rosary being said. Funeral practices vary across different cultures but tend to be ritualistic. The funeral "Mass of Resurrection" with the priest wearing white vestments has replaced the former "Mass for the Dead" with black vestments. Jesus's resurrection is recalled in the eulogy segment of the Mass as an example of hope for the deceased. Depending upon the wishes of the deceased, the body may be disposed of in any dignified way from donating it to science, cremation, or burial. The priest usually sprinkles "holy water" on the casket both at the Mass and again when it's placed in the grave, where prayers are offered for the progress of the deceased in the afterlife.

Typically there are black and white Protestant churches in America, and these groups have vastly different rites and funeral services. In black churches, being "funeralized" is highly elaborate, costly, and lengthy compared to in white Protestant churches. Mourning and funeral customs of the black church illustrates the persistence of traditions despite modernization and changes occurring across all Christian groups. Within the black community, there is a wide array of burial rites specific to their West African heritage. The key characteristic is that over a week's duration all the relatives come to pay respects. Funeralization involves eating, socializing, and the sharing of emotions that are expressed over a prolonged period. Black families expect to embalm their loved one and bury him or her in a respectable casket. Typically pastors and services tend to be animated and emotional with varying degrees of "hallelujahs," "amens," and "praise the Lords" from devotees. Several soloists are scheduled for funeral programs, with special printed and elaborate programs with pictures of the deceased and family over a lifetime. After the service and the interment, fellowship is celebrated in the church so all can resolve their sorrows with comfort food.

White Protestant churches vary in ritual, but most families embalm the deceased and view of the body in the slumber room of the funeral home or the church prior to the funeral. Modern wakes often involve slide shows of the deceased. The day after the wake, the funeral service is held at the home, church, mausoleum, or cemetery. Lutheran and Episcopal churches hold ritualistic services, while Pentecostal and Baptist groups emphasize evangelism during the service. Baptists do not pray for the dead because they believe their eternal outcome is already determined at death. Generally Protestant services involve a eulogy followed by a procession to the cemetery where the primary group gathers with or without a pastor for a short graveside interment service.

Hindu Funerals

A Hindu is a follower of the Manifestation of God Krishna. Hindu funeral rites are called *Antyesi*. This sacramental process differs across ascribed status in society. When a loved one dies, family members offer water to the body. After that, the corpse is washed and dressed in clean clothes. If the deceased is a married woman who dies before her husband, she is dressed in red bridal finery. The rest are dressed in white or pale clothes accented with sandalwood paste and tulasi. According to Antyesi, the body must be cremated before dawn of the day following death but, with morgues now available, this procedure need not be rigidly adhered to; thus family members who live a distance away have time to travel to view the body.

The body is placed on a funeral bier made of bamboo that is carried by four male members of the family to the cremation grounds located near a body of water. The funeral byre is placed in a funeral hearse and transported to the crematorium where the body is placed in an incinerator. After cremation, the leftover ashes and bone fragments are placed in a pot and thrown into the water.

Death in the Hindu family starts a period of intense pollution for the family members for at least 11 days. Immediately after the cremation, participants bathe and change clothes before

returning to the deceased's house. The following days are spent in bereavement with family gathering around a picture of the deceased and the priest reciting scripture. An oil lamp is always kept lit in front of the deceased's picture. Each of these days a food offering (*pinda daan*) for the deceased is placed by an altar located outside the house in a public area. On the 10th day, a formal funeral is performed, which includes making offerings into a consecrated fire and offering sacred water to the deceased and to ancestors. This is also the day when the period of pollution ceases and people shave and wash their hair. The eldest son or whoever has lit the funeral pyre will shave his head. The 11th day, the family comes back to normal living and the occasion is celebrated with a feast to which the extended family and neighbors are invited.

Jewish Funerals

The Hebrew scriptures portray an intimate relationship between *Yahweh* (God) and His believers throughout the life cycle. The Torah says little about afterlife, however, so Judaism is focused on this world and helping the bereaved family. Life after death for many Jewish groups lies with the legacy of the deceased family; hence, death represents a tragedy. The Jewish funeralization process is modest and simple. Upon death, bodies are cleansed in the synagogue. Funerals are divided into two services. The first is held at the funeral home or synagogue and the second at the cemetery. Funerals are simple with the rabbi employing psalms and prayers of comfort and an appropriate eulogy. The rabbi reads the solemn "God full of compassion" prayer and *Kaddish* prayer at the conclusion. Early burial has always been practiced by Jewish people. With white shrouds covering the body, the deceased is placed into a simple wooden box. At the conclusion of graveside prayers, dirt is shoveled into the grave.

Family mourning is divided into three parts. Mourners must receive the comforters and remain in deep contemplation. Then there is a 30-day period after the death when the mourner is restricted from attending community events. The third is a 12-month period of mourning, with other ritualistic requirements and stipulations for families depending upon the denomination.

Islamic Funerals

Although it is a time of grief, death is a gateway to a better existence. When a Muslim dies, loved ones offer the dying person their love and reminders of God's mercy and forgiveness. A Muslim's last words are to be the declaration of faith: "I bear witness that there is no God but Allah." Upon death, the bereaved are encouraged to be calm, to cry but not wail. They should pray for the departed and begin funeralization. The eyes of the deceased should be closed and the body covered with a white sheet.

Muslims strive to bury the deceased as soon as possible after death, avoiding mummification or cremation. In preparing the body, family or community members wash and enshroud the body in sheets of white cloth. Martyrs are buried in their own clothes. The deceased is transported to a public area for funeral prayers instigated by an imam (clergy), joined by loved ones and community. The deceased is then transported to the cemetery for burial.

Although members of the community participate in funeral prayers, only males accompany the body to the cemetery. Muslims prefer to be buried in a Muslim cemetery located close to where they died. The corpse is laid in the grave with or without a coffin (as local laws permit) on his or her right side, facing Mecca. Muslims have simple gravesites without elaborate markers. Families observe a 3-day period of prayer, seeing friends and avoiding decorative ornamentation of self. In accordance with the Qur'an, widows observe an extended mourning period of approximately 4 months.

Zoroastrian Funerals

Zoroastrianism (1800–1500 B.C.E.) is an old religion. Followers of the Messenger Zoroaster, Zoroastrians believe in two forces. There is one universal, transcendent God (Ahura Mazda) and His angels versus the devil, who is aided by evil spirits. Before death, a Zoroastrian is to recite the prayer for repentance, followed by several other prayers. A lamp used as a symbol of a dispeller of evil is then lit and placed close to the dying person's head. Then pomegranate juice is consumed as a symbolic gesture of preparation for immortality.

When the person dies, a prayer vigil typically occurs, along with a chanting hymn, a repetition of confessional, and an invocation of the messenger divinity. The body is cleaned for rituals to follow either by corpse cleaners or family members of the same sex. Body preparation for burial include the deceased being dressed in white (the color representing "Mazda") clothes with hands placed across the chest and legs crossed, with face exposed. The body is laid on stone floors facing southward (the location of heaven). The number three—representing good thoughts, words, and deeds—is represented in the drawing of centric furrows around the body, with prayers recited, while oil lamps are lit to dispel evil. The funeral occurs within 24 hours, during daylight to keep evil pollution away. Two magi perform the rite of faith or service, after which the face of the deceased is covered and loved ones pay final respects prior to burial.

The bier is carried by loved ones, or the corpse is placed in a hearse that travels to the funeral site followed by a procession of relatives and friends. The historical "funeral tower," where Zoroastrian corpses were placed facing the East for quick decay or consumption by vultures, is what makes their funeralization unique. However, Middle Eastern and industrialized countries tend not to do this, so other options are employed like ground or wall burials. After the burial, relatives and friends bathe to avoid being polluted by evil spirits.

Christopher J. Johnson

See also Buddhist Beliefs and Traditions; Christian Beliefs and Traditions; Eschatology; Hindu Beliefs and Traditions; Jewish Beliefs and Traditions; Muslim Beliefs and Traditions

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Gender and Death

All people die, men and women alike, but there are some interesting differences in how men and women approach death and dying. In the past, men and women had different experiences with the dying process. Historically men experienced death by seeking it out or confronting it in a predominantly male context. Men were more likely to be employed in hazardous occupations such as mining, to be engaged in military combat, or to pursue dangerous lifestyles. Women encountered death at home, by caring for seriously ill family members, preparing the dead, and comforting the bereaved.

Currently most Americans die in an institutional setting, with nearly one in five older adults dying in a nursing home, and many more die in a hospital than at home. Death in late life is often the result of a decision to halt futile or unwanted medical treatment after a period of chronic illness and dependency. Whereas the circumstances of death may be similar for men and women, the response to one's own terminal illness, socially constructed attitudes toward death, the experience of caring for dying people, and the response to loss, grief, and bereavement are likely to be quite different for men and women. This entry explores differences in life expectancy and primary causes of death between men and women, how gender might affect one's desire for a hastened death through suicide or physician-assisted suicide, and gender differences in grief and bereavement.

Life Expectancy

On average women live longer than men. Worldwide life expectancy for all people is 64.3 years; for males it is 62.7, and for females it is 66 years. Around the globe women live longer than men, except in 10 countries, including Pakistan and Bangladesh, in part due to female infanticide. The sex difference ranges from 4 to 6 years in North America and Europe to more than 13 years between men and women in Russia. Women's greater longevity means that elderly women are forced to live with death longer than men. Having faced the death of partners, peers, and family, women must then face their own death, often without the support of a spouse.

The decisive advantage females have in life expectancy is the result of excessive male mortality at all ages, beginning with fetal deaths. More males than females die during childhood, primarily due to infection, which suggests immune system differences. By early adolescence numerical parity is achieved, but in early adulthood more males than females die due to accidents and violence. Eighty-five percent of centenarians are women, but the men in that group are in better shape physically and cognitively. Gender differences in life expectancy disappear at age 105. Men who survive to age 105 represent the fittest of their sex and have outlived the disadvantages of being male.

The reasons for the difference in life expectancy between males and females are not fully understood. Women appear to outlive men due to both lifestyle and biological factors. Lifestyle factors

that disadvantage males include their greater likelihood of employment in hazardous occupations and the fact that men generally drive, smoke, and drink more than women do. Men are more often the victims of homicide and also have higher rates of suicide.

Some scholars argue that women are biologically superior to men. Shorter male life expectancy may be another manifestation of the general rule among all mammal species that larger individuals tend on average to have shorter lives. Women survive the worst conditions better than men and are better able to endure environmental hardships such as cold and famine. Women have less body mass on average than men, need less food to survive, and have twice the percentage of body fat and thus better insulation. Premenopausal women produce estrogen, which has a protective effect against heart disease and other chronic conditions. Menopause may also be a means of protecting older women from the risk of death through childbirth.

Women have two sets of X-linked genes, which may be protective. Men have an X and a Y chromosome, and many of the defective genes that cause diseases such as hemophilia and color blindness are on the X chromosome. Women can compensate for a defective X chromosome gene if the counterpart gene of their second X chromosome is functioning properly. Thus, women's second X chromosome may be a longevity factor in itself.

There have recently been modest declines in the life expectancy differential for men and women. Two new factors have been influential. Men's survival rates are increasing somewhat more rapidly than women's, probably reflecting a decrease in deaths from heart disease. Lung cancer rates are increasing faster for women, reflecting the greater numbers of women who began to smoke 30 or 40 years earlier.

Causes of Death

Heart disease and cancer are the leading causes of death for both men and women. Like differences in life expectancy, differences in causes of death reflect differences in biological and lifestyle factors. Unintentional injuries are the third leading cause of death for men, but only the sixth leading cause for women. Alzheimer's disease is more likely to be the cause of death for women than for men, perhaps as a result of longer life expectancy. Suicide is the eighth leading cause of death for men but does not make the top 10 causes of death for women.

Top causes of death for men in descending order are heart disease, cancer, unintentional injuries, cerebrovascular diseases (stroke), chronic lower respiratory diseases, diabetes, influenza and pneumonia, suicide, kidney disease, and Alzheimer's disease. Top causes of death for women in descending order are heart disease, cancer, cerebrovascular diseases (stroke), chronic lower respiratory diseases, Alzheimer's disease, unintentional injuries, diabetes, influenza and pneumonia, kidney disease, and septicemia.

Hastened Death: Suicide and Physician-Assisted Suicide

There is evidence that older women are disadvantaged in their treatment by the medical profession. The relative lack of medical research on aging and female biology significantly limits the quality of medical care available to older women, whose longer life expectancy places many at risk for experiencing prolonged frailty and chronic health problems. Women experience depression about twice as frequently as men and are at greater risk for inadequate pain management, both of which have been associated with a desire to die. Although there are reasons to suspect that gender may play an important role in increasing older women's vulnerability to hastening their deaths through suicide or physician-assisted suicide, this does not appear to be the case. Women are less likely than men to kill themselves or to ask a physician for a lethal prescription to help them die.

In the United States, suicide rates are highest among older adults, males, and Caucasians. Men are 3 times more likely than women to kill themselves. In the United States, white men over age 50 represent approximately 10% of the total population but constitute 28% of suicides. Men may give in to the stress of physical illness, loneliness, and depression. Male suicides after retirement may be precipitated by a reduction in a man's capacity to work, a lessening of his capacity to function independently, or by a diminution of his means of exercising control. These three precipitating factors may be more essential to the ways in which men, as opposed to women, organize their lives.

In the United States, physician-assisted suicide is legal only in Oregon and is defined as a patient asking a physician to prescribe a lethal dose of medication under certain conditions. Patients eligible for physician-assisted suicide have to have been diagnosed with a terminal illness or end-stage condition that is expected to cause their death within 6 months, must be free of depression or other mental illnesses, must be residents of Oregon, and must know about options for pain management and end-of-life care such as hospice or palliative care. Since the Death with Dignity Act was passed in Oregon in 1997, by 2007, the last year for which data are available, 292 patients have died under the terms of the law. Approximately equal numbers of men and women died after ingesting a lethal dose of medication: 54% men and 46% women. Thus, when clinical guidelines are in place, there are no apparent sex differences among those who chose to hasten their deaths through legal physician-assisted suicide.

In the 1990s, pathologist Jack Kevorkian assisted with the deaths of over 100 individuals in Michigan. His actions were illegal, and no clinical safeguards protected the patients who sought his assistance in ending their lives. In a careful study of 69 of these individuals for whom autopsy and medical records were available, 71% of those who died with Kevorkian's illegal assistance were women.

Grief and Bereavement

At the start of the 20th century, dealing with the dead and caring for the bereaved were considered women's tasks. Today death and bereavement are professional occupations, and death work shows gendered patterns. Paid professionals in the bereavement business tend to be women, and those who care for the corpse are almost always men.

Men and women may react to grief and bereavement in different ways. Men tend to work to resolve their grief. Women are more likely to feel that grief has be lived with rather than resolved. There is one especially female mode of experiencing death: death in pregnancy, from abortions, and during or after childbirth. The biological experience of pregnancy and childbirth combined with the social role of motherhood may make a mother's grief and bereavement different from that of the father. Bereaved mothers report not "getting over" the loss of a child, but instead describe a process of rebuilding their lives around that loss.

Women are more likely to outlive their husbands due to greater longevity. Widowers and widows are perceived differently, which is likely an extension of the double standard that also affects older men and women. Older men with graying hair and expanding waistlines may be seen as successful, but women with gray hair and extra pounds "have let themselves go." Similarly, widowers are seen as more desirable, and are rarer, than are widows. The taint of death that attaches to widows marks them as socially undesirable. When a woman's husband dies, she may be seen as an object of pity or someone to be avoided. Widows tend to be seen as either socially uninteresting or as predators who are after other women's spouses. The bereaved widow reminds others of their own or their partner's death. Many women refuse to join widow's organizations because they do not wish to be identified stigmatically as widows.

In sum, when death is encountered, it may be identical or a completely unique experience for each individual. However, differences in life expectancy, causes of death, desire for death, and experience with the deaths of others show interesting gendered patterns.

Lori A. Roscoe

See also Aging, the Elderly, and Death; Causes of Death, Contemporary; Euthanasia; Infanticide; Life Expectancy; Suicide

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Genocide

Genocide is the attempt to eradicate a people due to their race, religion, ethnicity, or nationality, usually by means of mass slaughter. The Holocaust, in which the Nazis murdered about 6 million Jews along with millions of others, is probably the most widely known genocide of the 20th century. Although the Holocaust may be unique in other respects, it is not unique in its being a genocide. Over the 20th century and into the 21st century, genocide has occurred in Cambodia, Germany, Iraq, Turkey, and Rwanda, and intervention has been rare. Some of these acts of genocide were probably preventable, and great harm might have been averted had the international community taken swift, decisive action.

Definition, Use, and Differentiation of Categories

The word *genocide* is relatively new, originating in the mid-20th century, when it was created by a Polish-born lawyer, Raphael Lemkin, who needed a term describing acts aimed to destroy entire races or cultures. Lemkin created a word using the Greek term *genos,* denoting race or tribe, and *cide,* a derivative of the Latin *caedere* "to kill." At the end of World War II, as the extent of the crimes perpetrated by the Nazis during the Holocaust became clear, the international community was ready to declare genocide a crime. The General Assembly of the United Nations passed a resolution condemning genocide on December 11, 1946, and on December 9, 1948, it passed the Convention on the Prevention and Punishment of the Crime of Genocide, widely known as the Genocide Convention.

The Genocide Convention defines genocide as acts committed with the intent to destroy, in whole or in part, a national, ethnical, racial, or religious group. Included in such acts are killing members of the group, causing serious bodily or mental harm to them, inflicting conditions of life calculated to physically destroy the group, imposing measures intended to prevent births within the group, or forcibly transferring children of the group to another group.

Perpetrators of genocide rarely describe their actions using the terms employed in the Genocide Convention. Instead, they devise a coded language loaded with euphemisms. The Nazis used expressions such the famous "final solution" and other phrases such as "special treatment" or "evacuation" to designate systematic programs of murder conducted on a massive scale. "Ethnic cleansing" was widely employed to describe what took place during the genocide in the Balkans. Manipulation of language can obscure what is actually taking place and help perpetrators to mentally distance themselves from the moral implications of the atrocities they commit.

Persons affected by, or engaged in, genocide can be differentiated by category. These categories include perpetrators, victims, bystanders (which may include individuals, communities, nongovernmental organizations, nations, or the international community itself), and rescuers who come to the aid of those targeted by a genocidal regime. This list is not exhaustive and other categories can often be distinguished. For example, there may be individuals or groups engaged in resistance—a category frequently overlooked but deserving of recognition. Individuals sometimes fall within more than one of these classifications. The same individual may be a rescuer or resister and also a victim. More rarely, a perpetrator may also be a rescuer. The Nazis are paradigmatic perpetrators, yet a few party members acted as rescuers. Oskar Schindler is probably the best known of these, due to the popular film *Schindler's List*, but he was not the only party member to engage in rescue efforts.

Reasons, Motives, and Methods

There is no known single motive or reason for genocide. The Nazis were motivated primarily by concerns for racial purity. The Khmer Rouge, responsible for the genocide in Cambodia in the latter half of the 1970s, were intent on creating what they took to be an ideal communist society, and they eliminated anyone they believed might obstruct this project. The genocide perpetrated by the government of Turkey in 1915 against its Armenian population was apparently motivated by concerns for national security, as was Saddam Hussein's genocide directed against the Kurds of Iraq.

A common feature of genocide is the presence of a hated group, members of which are perceived or represented as a threat. The Nazis represented Jews as a threat to the purity of the Aryan race and as destroyers of German culture. They used already existing stereotypes provided by centuries of vilification of Jews by the Christian communities of Europe and transferred preexisting religious hatred to race, utilizing the then-popular views promulgated by the eugenics movement to lend the transfer a veneer of scientific credibility. The Khmer Rouge massacred Buddhists and Muslims because of the supposed incompatibility of religious commitment with communism. Buddhists and Muslims were believed to threaten the realization of the society the Khmer Rouge sought to establish. Saddam Hussein unleashed execution squads and gas attacks against the Kurds, a stateless people spread over Iraq, Iran, Syria, and Turkey, during the war between Iraq and Iran in the 1980s. He apparently believed that some of Iraq's Kurds had allied themselves with Iran, and set about systematically destroying the way of life of the Kurds of northern Iraq in order to reduce this supposed threat to national security. The government of Turkey, allied with Germany during World War I, suspected that some of Turkey's Armenians were aiding opposing powers. The Armenians were taken to pose a threat to national security, and their elimination was a way of resolving this issue.

The methods employed in the commission of genocide vary. The Nazis employed the most advanced technology available to construct death camps modeled on industrial production to obtain the most effective and efficient means of extermination. They also utilized cutting-edge data-processing technology to maintain records. Saddam Hussein used sophisticated chemical weapons against the Kurds. However, the Nazis and Saddam Hussein also employed less sophisticated methods, such as rounding people up and shooting them. Little in the way of advanced technology was used in Rwanda or Cambodia. Many victims in Rwanda were chopped to death with machetes or bludgeoned with clubs. The Khmer Rouge slaughtered many using workshop and agricultural tools, such as axes and hoes.

Genocide and War

Genocide is often initiated under the cover of war. The government of Turkey perpetrated genocide against Turkey's Armenian population during World War I. The Holocaust occurred during World War II. Saddam Hussein's genocide against the Kurds happened during the Iraq–Iran war. The Rwandan genocide, in which a Hutu-led government orchestrated the slaughter of about 800,000 people, mostly Tutsis, took place in the presence of a UN peacekeeping force dispatched to secure a cease-fire designed to end a civil war, which rekindled when the genocide commenced. The genocide in Darfur began when the Republic of Sudan was fighting insurgency in the south, which spread into the western portion of the country. With its military resources committed in the south, the government established, supported, and utilized unofficial militias in the western region, and these militia groups have been the primary perpetrators of genocide in Darfur.

The cover of war frequently obscures the beginning of genocide. It is expected that a great deal of killing will occur in war. Given the increase in the number of noncombatant casualties associated with modern warfare, the start of genocide may be difficult to distinguish from massive collateral damage. In the confusion and dislocation brought about by war, distinguishing perpetrators from victims is often difficult. War sometimes delays a response to genocide, because the top priority is usually ending or winning the war; intervening in genocide then becomes a secondary consideration.

Recognition of, and Response to, Genocide

Once genocide is identified, there is often reluctance to give it official recognition. Recognition

brings some expectation of action, and governments are sometimes reluctant to act. Conflict with established geopolitical commitments is one reason for inaction. During the cold war, political alignment and balance of power were of overriding concern to the world's major powers, and this influenced the treatment received by the Khmer Rouge subsequent to the discovery of its atrocities. The Vietnamese invasion of Cambodia in 1979 exposed the genocidal program of the Khmer Rouge. Vietnam was allied with the Soviet Union and was widely represented as an aggressor nation by powers aligned against the Soviet Union. These powers were reluctant to undermine the legitimacy of the Khmer Rouge on the grounds of its genocidal activities, because this would have the effect of justifying the Vietnamese invasion. In the case of Iraq, there is little doubt that economic interests related to oil and trade had an effect on the political stance taken toward Saddam Hussein's regime. Public outcry over the alleged use of weapons of mass destruction far exceeded condemnation of his genocidal activities. The oil flowing from the Republic of Sudan has probably retarded robust action by the international community to bring the genocide in Darfur to a halt. Another reason stems from the system of international relations and law issuing from the Treaty of Westphalia (1648), which is taken to establish the absolute sovereignty of national governments in the administration of their own territory and treatment of their own citizens. As long as genocide remains confined within the borders of regimes that perpetrate it, intervention is conceived as a violation of that state's sovereignty. With the exception of intervention by NATO forces in Kosovo in 1999, genocidal programs have met with little or no resistance from the world's major powers.

Future of Genocide

There are some bright spots on the horizon indicating that the means to future improvements in the early identification of, and response to, genocide are becoming increasingly available. Sophisticated satellite surveillance makes it less likely that genocide can go undetected for long, and Internet communication makes it harder for genocidal regimes to suppress information about their activities. The International Criminal Court, the first standing court empowered to try perpetrators, makes it less likely that those with genocidal ambitions can harbor realistic hopes of escaping punishment. The intervention by NATO into the "ethnic cleansing" in Kosovo indicates that the absolute sovereignty of states may be conditioned by egregious violations of human rights. The "Responsibility to Protect," known as R2P, was developed by the International Commission on Intervention and State Sovereignty in 2001 and adopted by the World Summit in 2005. It provides further grounds for intervening in the affairs of a state that perpetrates, permits, or cannot prevent massive human rights abuses. Although R2P has significant support, some argue that it permits too much infringement on state sovereignty. These are promising signs but are unlikely to have much effect unless the political will of governments to take action is strengthened. If economic and geopolitical interests continue to play determining roles in responding to genocide and intervention is stymied by concerns over violating the absolute sovereignty of states even when they perpetrate massive human rights abuses, improved communication technology and early detection may be of limited value to the prevention of genocide.

Michael R. Taylor

See also Death Squads; Holocaust; Massacres; Memorials; Race and Death

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Ghost Dance

The Ghost Dance of 1890 was an American Indian religious movement that was based on the return of prosperity for Indian peoples in the face of the depressed conditions that existed on American Indian reservations. The movement featured the belief that good living and the peaceful accommodation to whites would bring about the resurrection of their dead relatives and a return of the old way of life. It is referred to as the "Ghost Dance" because of its relation to the spirits of the dead of the participants who were often seen during visions obtained during the dance. The Ghost Dance of 1890 is distinguished from an earlier, smaller, less successful movement known as the Ghost Dance of 1870.

Origins

In late 1888 on the Walker River Reservation in Nevada, a Northern Paiute American Indian named Wovoka (Jack Wilson) fell ill. During his illness he had a religious vision in which he was taken to the Spirit World. There he was given sacred instructions and a message for Indian people. They were to be good to one another and be at peace with the whites, they were to work hard, and they were to perform a dance for 5 straight days. If they followed these instructions, Wovoka prophesied, the world would be renewed, which included the return of the Indian dead.

The late 1800s is a time period that marks the end of the freedom for American Indians, especially those of the Great Plains. By 1890 these groups were either removed to reservations in Indian Territory (present-day Oklahoma) or were placed on reservations in the general vicinity of their earlier homelands. Their way of life, from the village-dwelling horticulturalists to the nomadic tipi-dwelling buffalo hunters, was forever altered. Every aspect of their cultures, from what they ate, to how they structured their families, to their religious perspectives on the world, soon came under attack by the U.S. government. A variety of policies were enacted with the intention of assimilating native peoples into the broader American culture.

Under this extreme pressure, native peoples turned to the supernatural for guidance and assistance, with few results. Word spread of the Paiute prophet Wovoka and his message of renewal, of the return of the dead, and of the return to earlier ways. Representatives from tribes came to visit Wovoka and listen to his message of hope and renewal. The Ghost Dance teachings and dance quickly spread to many other tribes. Tribes that participated in some form of the Ghost Dance movement included Arapaho, Arikara, Assiniboine, Caddo, Cheyenne, Gros Ventre, Iowa, Kiowa, Lakota, Mandan, Osage, Oto, Pawnee, Plains Apache, Ponca, Quapaw, Santee Dakota, Wichita, and Yanktonai Dakota.

Ghost Dance Forms

Wovoka's original Ghost Dance was derived from the Paiute round dance, a world renewal ceremony. Instructions given to him in his original vision provided the basic beliefs of the dance as well as the form of the dance. The Ghost Dance provided a mechanism for the return of the old ways, a time when the various peoples had control over their own lives and were free, and their way of life worked for them and made sense. The dance was a simple round dance, a circling of dancers in a clockwise direction to music for hours at a time. During the dream-like state induced through repetitive dance, participants would visit their deceased relatives in the land of the dead. In these visions they would see their relatives living the old way of life and where game was bountiful. Dancers wore shirts and dresses that were created specifically for the Ghost Dance, which were decorated with symbols seen in their visions.

As the Ghost Dance spread and was adopted by new tribes, it was variously adapted to local beliefs and dance rituals. Groups added elements of their own rituals, such as a center tree or pole, which some employed in their sun dances. Others added preparatory rituals such as the sweat lodge or other dances. Symbolic elements from tribal religious beliefs were often incorporated as well. These various groups made the Ghost Dance relevant to themselves through these changes. Also, new aspects, particularly songs, were continuously added through visions obtained while dancing.

Ghost Dance Among the Lakota

The Ghost Dance is perhaps best known among the Lakota or Sioux Indians of South Dakota. The

Lakota adopted the Ghost Dance and infused it with aspects of their own culture. In addition to believing that there would be a return to the old ways by supernatural intervention, the Lakota form included Ghost Dance shirts that were believed to repel bullets. This new addition alarmed officials and local settlers and created a high level of fear. This culminated in the massacre at Wounded Knee, South Dakota, where American soldiers intercepted a band of Ghost Dancers led by Chief Bigfoot. The soldiers subsequently massacred more than 150 men, women, and children.

Ghost Dance Beyond 1890

The tragedy of Wounded Knee, along with the failure of the dead to return among other tribes, led to the eventual end of the Ghost Dance for most groups. However, several Ghost Dance leaders continued to preach the Ghost Dance beliefs after 1890. Several tribes on the southern plains continued to perform the Ghost Dance into the 1910s. It eventually spread northward into Saskatchewan, where it persisted in a derivative form known as "new tidings" until the 1950s.

Erik D. Gooding

See also American Indian Beliefs and Traditions; Communicating With the Dead; Dance of Death (*Danse Macabre*)

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Ghost Month

The annual reunion of the dead and the living, known as Ghost Month or Hungry Ghost Month, is the most important Chinese festival of the dead. Daoists (also known as Taoists), Buddhists, and Chinese folk religion believers observe it. During Ghost Month, an annual month-long furlough from Hades is given to all of its inhabitants. During this period, the spirits of all the dead return to earthly existence to visit their families and others. Ghost Month is observed during the entire seventh lunar month, and it is observed in its purest form in Taiwan. During this festival, activities include the preparation of elaborate food offerings, decorating temples with lights and lanterns to guide the spirits, offering prayers for the dead, and the burning of ghost money. Insight into Chinese eschatology is helpful to grasp the significance of Ghost Month. This entry describes Chinese eschatology and the polytheistic elements of Chinese culture, the activities that take place during the observance of Hungry Ghost Month, and its cultural significance.

Chinese Eschatology

In Chinese culture death is not the final annihilation of self but an alternate, spiritual form of existence. Upon death, the soul of an individual undertakes a 7-week journey traveling through the *yin* world, the otherworld. In this journey the deceased pass through various gates and courts where trials are held and judgments made regarding the deceased's conduct in life on earth. Ultimately the soul reaches Hades, the abode of the dead, and lives under the rule of the *Giam-lo-ong* (Mandarin: *Yen-lo-wang*), the main deity of the underworld.

Chinese eschatology posits an existence after death, but the Chinese concept of life after death portrays an existence not unlike earthly life. The existence of the dead in Hades has an economic counterpart in the world of the living in that it costs money, because it is believed the dead in Hades have needs. The dead need food and drink, housing, clothing, and all the other necessities that are required during life. These things must be supplied by the living, and it falls to the offspring of the deceased to assume this responsibility. The living care for the dead, and the dead are thought to take care of the living through their spiritual influence.

A Host of Ghosts

Within Chinese eschatology is the belief that when one dies, the spirit goes to Hades and will enjoy, if well provided for, an existence essentially the same as when alive on earth. Family survivors think of

the dead as viable entities who are only living in a different place. All disembodied spirits are known as *leng*, of which there are three categories: (1) recently deceased parents or relatives and long-deceased ancestors, (2) ghosts who have no living relatives to worship them and care for their otherworldly needs, and (3) gods. Gods are considered to be in the same generic category as ghosts and ancestral spirits because some gods are assumed to have once been mortals who led virtuous lives and became deities after death.

Chinese culture accommodates polytheism, and many Chinese worship multiple deities. Religious worship can be quite varied and may include Daoism (also known as Taoism), Buddhism, Confucianism, plus numerous folk and local patron gods, sea gods, and animistic deities. It has been estimated that there are in excess of 250 gods or deities that are worshipped.

Recently Deceased Parents and Relatives and Ancestors

The dead are believed to be aware of the living and, ideally, they guard the health and good fortunes of the surviving family members. Family members exert considerable effort to honor the spirits of their deceased kin and ancestors, especially parents, as well as the pantheon of gods, and they are particularly anxious not to incur the displeasure of either deceased relatives or gods.

Because the visiting dead are expected to feast, food and wine are offered to them. In addition to the food offerings, there are requirements for the burning of ghost money for gods, ancestors, and ghosts. There are numerous kinds of ghost money, which may vary somewhat from area to area.

The Uncared For

The second category of deceased spirits, the uncared for, are potentially harmful. It is this category of spirit that can be appropriately termed ghosts, or *kui*. The uncared-for spirits are called *hungry ghosts,* because having no living descendants, they have no one to supply them with food, drink, or money in Hades and are, thus, deprived, or hungry. Such ghosts may be malicious or at least mischievous and are likely to cause trouble, teasing humans or, in some cases, causing them harm. If the hungry ghosts are displeased, they can be particularly malevolent, bringing misfortune or disaster on the living.

The Observance of Hungry Ghost Month

At the break of dawn on the first day of the seventh lunar month, the gates of Hades are opened and the spirits are free to visit earth and roam about during their furlough from hell. Such spirits are of two varieties: the cared-for and the uncared-for ghosts. The cared-for spirits are those deceased individuals who have living descendants and relatives who make offerings of food and drink to them and send (burn) gifts of paper money, thus providing for their needs. Those with family ties are generally good-natured and spend their time partaking in the simple earthly pleasures of eating and drinking. The visiting spirits are supervised by *Tai-sai-ia* (Mandarin: *Ta-shih-yeh*), the deity who represents the underworld.

Special attention is given to the hungry ghosts. During this time, tables are set up outside homes and places of business to hold the offerings of food and wine. The offerings are usually located outside home or businesses in the hope that these ghosts will not come into the houses or stores to cause trouble or harm. Also, it is believed that hungry ghosts will steal the offerings for deceased ancestors or otherwise interfere with the family paying the proper respect and providing offerings to the ancestors and gods; this potential trouble is another reason for keeping the ghosts outside the home. If the offering is for a single offending ghost who is causing family misfortune, the offering is placed on the ground outside the rear of the house.

The principle activities of Ghost Month involve the presentation of offerings and sacrifices to the dead. For deceased parents and ancestors, families place special offerings of food, wine, flowers, and cigarettes on the family altar, although entire meals are sometimes laid out on the dining table, complete with dinnerware and chopsticks, with empty seats provided for each of the deceased. Because the dead are treated as if alive, offerings for the visiting spirits include food, ghost money, and entertainment. Beyond these offerings, there are also Chinese operas and puppet shows performed on street stages to entertain the visiting spirits, ghosts, and the living.

Ghost Month comes to a climax on the 15th day, which is called *Chung Yuan Festival*. This is a Buddhist festival marking the end of the annual period of meditation and prayer training for monks and nuns. On this date, there are sacrificial feasts in the temples, and there are elaborate changing ceremonies for the dead conducted by Daoist and Buddhist priests. On the final day of the seventh lunar month, the spirits of the deceased are summoned home, and the gates of Hades are closed until the next year.

The Function of Ghost Month

The activities that take place are directed at remembering the dead, including them in the social fabric, as well as eliciting amity between the dead and the living. The observance of Hungry Ghost Month is intended to address the special needs of the deceased and to conform to the traditional obligations of the living. Such activities also are reciprocal in nature in that the living are motivated not only by love and respect for the dead, but also by the expectation of benevolence on the part of the dead. By engaging in such behavior, the living attempt to ensure some control over their own lives and to maintain a social bond with the dead. Through the observance of Hungry Ghost Month, the living can reduce their own anxiety of death through recognition that the deceased continue a worldly existence. Through regular interaction with the dead, the living are able to more effectively deal with death.

Ghost Month is a time of anxiety for many individuals because of the possible misfortune that might be visited upon the living by a hostile ghost. It is also a time of festivity. The observance of Ghost Month also allows the living to engage in an act of altruism in giving to the uncared-for ghosts and their ancestors. Some families lay out extra food offerings for a deceased ancestor who was known to be a gregarious host and entertainer in life; thus it is assumed guests will also visit during Ghost Month. Perhaps most importantly, the annual reenactment of visiting between the dead ancestors and hungry ghosts and the living reinforces the notion of the continuity of the family and the spiritual immortality of the individual. Inasmuch as the dead survive in the memories and ritualistic behavior of the living, death itself is less feared. Even the plight of the hungry ghosts serves as reinforcement for the fabric of social life, for the message is clear: To be cut off from the kinship system, with its support and the attendant reciprocal responsibilities and obligations is, indeed, a grim prospect.

Clifton D. Bryant

See also Ancestor Veneration, Japanese; Daoist Beliefs and Traditions; Deities of Life and Death; Holidays of the Dead; Terror Management Theory

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Ghost Photography

Since the beginning of time, people have imagined ghosts to haunt the world. These creatures were thought to be either hindered in their transfer to the afterlife or reluctant to leave their loved ones like the restless spirit of Catherine in Emily's Brontë's epic novel *Wuthering Heights*. Ghosts were seen as troubled and eager to intervene in the affairs of the living. To the audience, their punishments and corrections of injustice defined moral guidelines.

Folk tales about ghosts found their way into novels, theater plays, and the illustrated press. In Renaissance times, people were excited to see visible ghosts evoked by the use of the camera obscura in combination with the effects of mirrors and smoke. The camera obscura, a darkroom that through a lens in the wall projected an image on the opposite wall, was a device used by astronomers and portrait painters. About 1600, the instrument was applied for entertainment purposes. The invention of the laterna magica, which projected glass slide images, is attributed to both the German

Athanasias Kircher and the Dutchman Christiaan Huygens. About 1800, moving lanterns created the eerie effect of ghosts approaching the audience. The German Paul Philidor de Philipsthal discovered the even more convincing back-projection display of ghosts, the "phantasmagoria," that was shown in Austria, England, and France.

The Belgium-born Étienne-Gaspard Robertson impelled the phantasmagoria to international success with "fantascope" ghost shows. In 1805, the Germans Schirmer and Scholl presented the "ergascopia," a camera obscura combined with mirrors. Whatever the technique, in this period lantern ghost shows were more than just entertainment, they were an enlightenment instrument to destroy superstition. It could be a risky business, however. A ghost show of the German entertainer Oehler in Mexico City in 1806 put him in prison for months, as he was suspected of diabolic magic.

The projection of ghosts by painted glass slides in a magic lantern was popular entertainment well into the 19th century. After 1839, the suggestive reality of the new medium of photography increased the persuasiveness of projected ghosts. Photographs documented living and deceased loved ones in family albums, picture frames, or medallions. Photographs of ghosts appeared, showing dead people as transparent, supernatural apparitions that were meant to convince people of either the existence or the nonexistence of ghosts. Furthermore, photos originated which, to the willing beholder, depicted real ghosts by coincidence. It is a genre of ghost photography that still is very popular today, as can be deduced from the numerous ghost photos on the Internet.

Photography, the production of images by means of light, was considered a medium perfectly equipped to depict ghosts. The alleged objectivity of photography contributed to its reputation as a reliable and scientific medium. Nevertheless, photography sometimes instigated feelings of superstition. To some, photography seemed as if it could take possession of one's shadow and spirit. In line with this reputation was the medium's fame as an instrument that documented death and afterlife.

Ghost photography had innocent origins in early photographic experimentation. Long exposure times turned people into vague, see-through figures. It was the inventor Sir David Brewster who understood that this quality could be used to create "ghosts." His stereoscopic device caused a sensation in 1857 with a series of colored ghost scenes. An American, William Mumbler, is credited as the first to have photographed a spirit. The success of his photo of a deceased cousin started his career as a spirit photographic medium in 1862. In England, the first examples of ghost photography appeared in 1872. A portrait of the famous medium Elizabeth Guppy and her husband depicted a third veiled person. Many examples of spirit photography soon followed. By the end of the 1800s, spirit photos became crude and hardly convincing, sometimes even comical. By about 1900, the public preferred the moving ghosts of early cinema.

Moving and Moralizing Ghosts

Motion picture photography, or film, emerged about 1895. Film would add a new dimension to ghost photography by opening up new ways of storytelling. In 19th-century photography, depending on the presenter's focus, the audience was to be convinced of either the reality or the absurdity of the existence of ghosts. In 20th- and 21st-century film, however, spirits appeared not only in fantasy films or horror movies but also in stories dealing with social and moral dilemmas.

Early cinematographers, who had often been magicians and magic lantern operators, introduced ghostly themes in the new medium. The Frenchman George Méliès produced short films like *The Vanishing Lady*, in which a woman transformed into a skeleton. The Lumière brothers were also involved in ghost movies. The English hypnotist and telepathist George Albert Smith included photography and motion pictures in his theater shows. In America, it was Thomas Edison who started producing films of ghostly antics. In the early 1930s, when Hollywood dominated the international film industry, the adoption of synchronous sound coincided with the implementation of rear screen projection.

When movie studios set up special effect departments, ghost movies became increasingly elaborate. Modern ghost movies consisted of horror films like *Poltergeist* and *The Others;* tragic love stories such as *What Dreams May Come* and *Meet Joe Black;* comedies such as *Ghost Busters* and *Ghost*; and adventure movies like *Pirates of the*

Caribbean and *Harry Potter.* On television, music clips like Michael Jackson's "Thriller" and shows like *Charmed* and *The Ghost Whisperer* were successful. Katherine Fowkes has analyzed convincingly the function of ghost movies as vehicles to address delicate issues. As in literature and popular culture, movie ghosts acted as mediators between the living and the dead, conveying messages of moral import. In contrast to the withered creatures of horror movies, in these films ghosts appear as complete and unwounded.

A striking example of a ghost film with an intended moral was the first major pacifist movie *J'Accuse* made by the French director Abel Gance in 1919 (1939), condemning the horror and absurdity of war. In *J'Accuse*, two men meet in the trenches. Although the one man has an affair with the wife of the other, they reconcile their differences. The movie's message is that if the two soldiers can make peace, so could politicians. The film is all the more impressive for its location on the World War I battlefields of France. Unforgettable is the final scene, in which dead soldiers rise from their graves, walk through the countryside, and demand accountability for their sufferings.

A comedy film, *The Canterville Ghost* (1944), addresses war differently. It presents a ghost that in life was Sir Simon of Canterville, who in the 1600s fled a duel and found refuge in the family castle. His ashamed father dooms him to be a ghost until one of his descendants performs a brave deed. Simon believes he may be saved by Cuffy Willams, an American kinsman stationed with a troop of soldiers at the castle in 1943. *The Canterville Ghost* was intended to improve the hostile relations between the British public and the American servicemen in the United Kingdom, who were regarded as "overpaid, oversexed, and over here."

A Matter of Life and Death, retitled *Stairway to Heaven* (1946), had the same purpose. The movie describes Royal Air Force pilot Peter Carter, who tries to escape a burning Lancaster bomber. He makes radio contact with June, an American radio operator based in England, and carries on a tender conversation with her before he jumps without a usable parachute. Peter doesn't die because of a mistake of Conductor 71, his guide from the "other world." Instead, Peter wakes up near June's base, and they meet and fall in love. Conductor 71 tries to convince Peter to accept his death, but Peter demands an appeal and so appears before a celestial court. June's friend, the late Doctor Reeves, pleads Peter's case arguing that Peter has fallen in love and now has an earthly commitment that takes precedence over the afterlife's claim on him. Reeves has June take the stand, while she is asleep in the "real world," to testify that she is prepared to give her life to save Peter. When she steps on the stairway to heaven (depicted by a moving escalator), it stops to give her back to Peter.

Ghosts as Emancipators

Ghost movies provided vehicles for staging fantasies of sexuality, illustrating ethnic problems in society, and changing gender roles. A movie like *Topper* (1937) allowed for the "sex-without-the-sex" genre to avoid censorship of the motion picture production code. Ghost fantasies were combined with "black" characters to express spirituality and soul. Music and supernaturalism became emblematic of racial expectations in culture at large. In Hollywood movies, the threat of the "other" was exaggerated in stories about miscegenation and ghetto-ridden crime. In some cases, the threat is diminished by representations of African Americans as musicians, performers, or as kind spiritual advisors. A film like *The Night of the Living Dead* (1968) opposes the supposed qualities of "white" people to the soulfulness of "black" culture.

The marginal place of nonwhites in society and the masochistic role of ghosts in films of the 1990s are combined in movies like *Ghost* (1990). Here, the murderer Willy is presented as male, Puerto Rican, and evil. Oda Mae's character is that of the stereotypical mammy helper with her comic antics. The one person able to access the supernatural is both black and a woman, meeting stereotypes in popular culture. The film *Heart Condition* (1990) refers even more directly to the relationship between the ghostly state and racial inequalities. Here, a racist cop receives the heart of an African American lawyer donor and inherits his ghost. As in the movie *Ghost Dad* (1990), the film contains jokes about the protagonist's manhood that are in line with racial stereotypes.

Fowkes stated that reasons for the prevalence of fantasy films can be found in sources of modern-day

stress such as changing race and gender hierarchies. In the United States, the aftermath of the wars in Korea and Vietnam, race riots, assassinations, and Watergate set the stage for a new sense of public reality in which male authority figures became vulnerable. In response, Hollywood cinema aimed to correct the gender imbalance through a reassertion of patriarchy.

After World War II, when women working in male-designated jobs were restricted to home and family life again, movies addressed changing gender roles. Here, the protagonists are ghostly helpers appearing as angels. *It's a Wonderful Life* (1946) presents George Bailey dealing with dilemmas of male ambition versus domesticity. He is saved by the angel Clarence. In *The Bishop's Wife* (1947) the angel Dudley intervenes in job and marriage trouble. The protagonist in *The Ghost and Mrs. Muir* (1947) mobilizes gender stereotypes also. This movie is about the romantic relationship between an independent widowed woman, Lucy, and a dead captain's ghost. The female character's striving for independence and emancipation is hindered by her relationship with the male ghost.

More recently, the effects of women's emancipation were dealt with in *The Sixth Sense* (1999). In *The Sixth Sense* a psychiatrist who cannot express himself emotionally aims to help a boy plagued by visions of dead people. This film, like *Ghost*, *Ghost Dad*, and *Truly, Madly, Deeply* (1991), focuses on the difficulty of communication between men and women and the distant husband or father in American families. These ghost films deal with stereotypical gender relationships, portraying men as obsessed by work, distant from their wives and children, and unable to express themselves. Typically, these films have happy endings, with a male ghost finally succeeding in articulating his feelings for the people he loves.

Marga Altena

See also Literary Depictions of Death; Popular Culture and Images of Death; Zombies, Revenants, Vampires, and Reanimated Corpses

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Ghosts

Though possibly nonexistent, ghosts play a role in the human experience of death. Ghost stories are popular in most cultures, giving a glimpse of what life after death might be like, if real. There are three major issues to consider with regard to ghosts: (1) There are no scientifically acceptable reasons for believing in the existence of ghosts. (2) There is a philosophical question concerning the possibility of ghosts, conceived as immaterial personal agents. (3) There are other humanistic and social-scientific perspectives on ghosts.

Scientific Status of Ghosts as Immaterial Agents

Ghosts are usually regarded as immaterial, incorporeal, spiritual beings—souls without bodies. They are spirits of people who have once lived, have died, and have come back to haunt those who survived them, especially people who were close to them when they were alive or who had a special place in their lives. Ghosts, for some reason, cannot find rest in their deaths. The ghost is an apparition of a deceased person, returning to places where that person lived and/or died. Typically, something must be done by the living—for example, revenge a murder or correct some other injustice—in order to get rid of the hauntings. A person whose restless soul appears as a ghost may have suffered a violent death or committed suicide. Ghosts are often claimed to haunt an old, creepy house, for instance, or other places where something terrible happened.

There is no reason, in today's scientific age, to believe that such beings as ghosts actually exist. Parapsychology ("psychical research"), the discipline investigating alleged paranormal phenomena, such as hauntings or poltergeist, has for more than a century sought scientific evidence for the reality of life after death, including the reality of ghosts, with little success. Psychical researchers' methods have failed to meet the rigorous standards of scientific experimentation. Hence, parapsychology hardly deserves the status of a serious academic discipline, although in the late 1800s and the early 1900s, leading psychologists and philosophers, not to talk about writers and other artists, were interested in it. Scientists and skeptics about the paranormal have vigorously challenged psychical researchers' claims to have discovered evidence for the reality of paranormal phenomena. Accordingly, while science cannot prove ghosts unreal, skepticism about them is the received view in the academic community. In addition, those who do believe in life after death for religious reasons (e.g., traditional Christians) also criticize parapsychological attempts to communicate with supposed ghosts and demons.

Philosophical Issue of the Possibility of Ghosts

Presumably, then, no rational thinker regards ghosts as really existing. The interesting philosophical issue is whether such (or any) incorporeal entities are so much as possible, that is, whether there even could be ghosts, and if so, in what sense. There seems to be no *logical* contradiction in the concept of a ghost (as in the concept of a round square). On the other hand, according to current science, ghosts are likely to be not just contingently nonexistent (like pink elephants) but physically (naturally) impossible, that is, their existence would contradict the laws of nature. Somewhat less clear is what philosophers may call the conceptual or metaphysical (im)possibility of ghosts. Also, one may ask whether ghosts can be persons and whether immaterial persons are possible.

The metaphysical (conceptual) possibility or impossibility of ghosts can be examined by comparing ghosts to other fictitious entities. What distinguishes ghosts from, say, vampires or zombies is that the latter are considered material agents, whereas ghosts are immaterial—minds, souls, or spirits without bodies. Alternatively, immateriality (incorporeality) can be required in a narrow definition of a ghost; in a broad sense of the term, all undead monsters, material or immaterial, could be described as ghosts.

There is no doubt about a vampire being classified as a person. Count Dracula, for instance, has (or would have, if he existed) many of the normal characteristics of a person. A zombie, on the contrary, is usually taken to lack mental life; it could hardly be a person. The interestingly problematic case is the ghost. In ghost stories, horror fiction, and popular culture generally, ghosts are regarded as personal: They are apparitions of individual people who have once lived, have died, and cannot find rest in death. A ghost is someone in particular—or the restless soul of someone in particular. Ghosts are also viewed as agents: They can move, walk through walls, touch and manipulate objects and people, and so forth.

However, while ghosts are not among the common objects of philosophical research, powerful philosophical arguments have been constructed to demonstrate the issue of agency. Seeking to demonstrate the impossibility of agency, Charles Taylor's transcendental argument for embodied agency goes beyond Immanuel Kant's criticisms (in the 1780s) of the fallacious attempts to rationally prove the existence of a substantial, immortal, personal soul. While Kant argued that nothing can be known about such a soul, Taylor—and the philosophers he relies on, Martin Heidegger and Maurice Merleau-Ponty—maintain that there can be no agency without bodily movements and orientation in space.

As one may argue for the metaphysical impossibility of ghosts, conceived as immaterial agents, one might more generally argue for the impossibility of any kind of incorporeal persons. If (potential) agency is required for personhood, and if the argument for the impossibility of disembodied agency is sound, then persons are embodied. If ghosts are immaterial agents maintaining their personhood after death, they might be impossible, necessarily nonexisting. There are innumerable metaphysically possible but nonactual worlds populated by vampires (though vampires are, presumably, also naturally impossible, as their existence would breach the laws of nature); there may be

none populated by ghosts. This argumentation may not demonstrate the impossibility of immaterial, disembodied agents objectively, from a third person point of view. Rather, it may work only subjectively from the first person point of view, showing that one could not coherently conceive of oneself as being a ghost, or any incorporeal agent (although one might, with some effort, conceive of oneself turning into a vampire). From the perspective of a person's own agency, that agency is necessarily embodied. Yet, many would claim that they can imagine turning into a ghost after death.

More generally, there are conceptual difficulties involved in the dualistic idea that the mind could be metaphysically separate from the body. On the other hand, ghosts are sometimes claimed to consist of a special kind of matter (ectoplasm), presumably scientifically unknown. If ghosts are material, after all, their impossibility cannot be demonstrated by the argument against disembodied agency. Nonetheless, the ethereal matter—vaguely materialized ectoplasm, or something else—that ghosts would then consist of requires explanation. Only highly unusual material beings, not recognized by science, can penetrate through walls, like ghosts are presumed to do. If ghosts were allowed to be material in this sense, it would, in principle, remain an open empirical issue whether there are any—whether, that is, science discovers such hitherto unknown matter.

Humanistic and Social-Scientific Perspectives on Ghosts

Apart from philosophical considerations, ghosts can be, and have been, approached from the perspectives of the different human sciences. Social scientists can inquire into the ways in which beliefs about ghosts arise and are spread and maintained in social and cultural groups. Statistics show that a significant number of people (even 20%–30% of the population) in advanced Western countries, such as the United States, believe in the existence of ghosts, although there is no scientific evidence for such beliefs. Why this is the case, and what kind of differences there are in the popularity of such beliefs in different social, religious, economic, or gender (or other) groups, can be studied in sociology and social psychology. The reasons why an individual believes in ghosts may, correspondingly, be examined by psychologists or psychotherapists. A therapist may be needed, if a person is seriously afraid of ghosts (or of becoming a ghost) in a way that disturbs his or her daily routines. Cultural anthropologists, in turn, may engage in comparative studies on the similarities and differences in beliefs in ghosts in cultural traditions and folklore. The formation and evolution of such beliefs in different cultures are also questions for historians of ideas.

The ways in which ghosts and hauntings, as rich cultural categories, structure experiences of time and temporality, especially the role played by memories of deceased people in experiences of places and objects as temporally "layered," provide ample material for cultural studies of various kinds, for example, cultural semiotics. Moreover, in theology and religious studies, one may examine the ways in which Christian and other religious orientations have faced popular beliefs in ghosts. Exorcising evil spirits (demons) is a traditional Catholic practice.

Ghost stories have been known from antiquity. While they have often been transmitted orally across generations, ghosts—like vampires and the other "undead"—have also been brought from folklore into "high" literature, especially gothic and romantic. For example, Henry James's novella, *The Turn of the Screw,* employs an impressive haunting motive. Especially in 19th-century Victorian literature, ghosts and haunting were an important theme; earlier, the apparition of Hamlet's father's ghost in Shakespeare's play is a classical case of a ghost on the scene. However, 20th-century modernist writing may also display ghost motives. Literary theorists can study not only the interpretation and aesthetic value of ghost stories and horror fiction generally, but also, in a more postmodernist or deconstructive vein, the ways in which the ghost-like presences or absences of the author or of various kinds of potential readers may haunt the structures of the text.

Horror has increasingly been recognized as an important aesthetic category. Ghosts are paradigmatic examples of supernaturally horrible things. Breaking the categorical divide between life and death, literary ghosts—again like the other "undead"—are aesthetically employed to evoke horror. Ghost stories question people's natural beliefs about the boundary between life and death, mixing these fundamental categories in an intellectually

challenging way. In addition to being horrible, ghosts may be depicted as unhappy creatures craving for rest, deserving sympathy and pity. Mostly, however, ghosts are met in popular fiction (say, Stephen King's novels) instead of serious literature. Above all, ghosts are, sometimes skillfully but often banally, pictured in movies. Stanley Kubrick's *The Shining*, based on a novel by King, is recognized as one of the more serious ghost movies made over the past few decades. Even popular depictions of ghosts in literature and film may, implicitly, raise philosophical questions, even if their artistic value is limited.

In addition to these examples drawn from Western culture, the concept of a ghost is important in Asian traditions in relation to the process of making the dead transform into benevolent ancestors. Especially in Chinese and Japanese cultures, it is widely believed that if the dead are not properly worshipped as ancestral spirits, they will haunt the living as ghosts.

The philosophical problem of how an immaterial ghost *could* be visible by living humans or harm (or help) them is usually left open in both literary and cinematic treatments of ghosts. Although ghosts are fictitious—even metaphysically impossible—stories and beliefs about them may have effects on people's lives. The conceptual category of a ghost is, then, an important one in structuring the human experience of mortality.

Sami Pihlström

See also Ancestor Veneration, Japanese; Death, Humanistic Perspectives; Death Superstitions; Ghost Dance; Immortality; Literary Depictions of Death; Mythology; Tombs and Mausoleums

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Gold Star Mothers

The term *Gold Star Mothers* refers to mothers who have had a child die in military service in time of war. The gold star comes from a service flag displayed by families of American service personnel to show the family had had a child in the Armed Forces of the United States. A blue star was displayed for each child serving in the military, but if the child died in military service, a gold star was sewn over the blue star, often showing a thin blue edge from the original star. From this group of women an organization was developed—American Gold Star Mothers, Inc.

Service Flags

Many countries pay special recognition to women whose children are in military service in time of war or military action. During World War I, families in the United States did this by means of a service flag. The flag was designed in 1917 by a captain in the U.S. Army, Robert L. Queissner, to honor his two sons who were serving in World War I. It was quickly adopted by the public and supported by government officials.

The service flag, also known as a service banner, consists of a white field with a red border, with a blue star for each family member on active duty. A gold star (often with a blue edge) represents a family member who died during military service, regardless of the cause of death. It is intended to give honor to any who died while in the military of the United States in time of war.

Because service flags have a gold star for each member who has died, the gold star and the term *gold star mother* was first applied to mothers

whose sons or daughters died in military service in World War I. The connection of the gold star symbol to mothers may have started because of the practice of a gold star being worn on a black mourning armband by a mother in memory of her deceased child. On May 28, 1918, almost a year after the first appearance of the service flags, President Woodrow Wilson approved a suggestion that women should wear on their left arm a black armband with a gold star for each member of the family who had lost his or her life for their country. The idea of displaying the gold star was considered to be a positive representation of the sacrifice made by those who had lost their lives for their country and the pride felt by family members regarding this supreme sacrifice.

The display of a service flag was officially authorized by the U.S. Department of Defense on December 1, 1967 (in Directive 1348.20). Congress approved a regulation that such a flag could be displayed by members of the immediate family. It could also be displayed by organizations such as churches, schools, colleges, fraternities, sororities, societies, and places of business with which the member of the U.S. Armed Forces was associated.

American Gold Star Mothers, Inc.

The service flag and its gold stars gave rise to a formal organization, American Gold Star Mothers, Inc., which was founded by Grace Darling Seibold. Her son, George, was an American fighter pilot in a Canadian unit of the Royal Flying Corps. He was reported missing in action in 1917. On Christmas Eve 1918, Mrs. Seibold learned of the death of her son when his personal effects were delivered to her home. Though grieving her son's death Mrs. Seibold dealt with her sorrow by working at Walter Reed Army Hospital helping injured servicemen. She not only worked to help the sick and injured, she also reached out to other bereaved mothers of deceased military personnel. She organized a group consisting solely of such mothers with the purpose of providing mutual comfort and to help provide personal care to hospitalized veterans confined in government institutions. The organization was named after the gold star on service flags that families hung in their windows in honor of a deceased serviceman or woman.

On June 4, 1928, 10 years after the death of her son, Mrs. Seibold and two dozen other mothers met in Washington, D.C., and established American Gold Star Mothers, Inc. This nondenominational, nonprofit, nonpolitical group was composed of women who had lost a son or daughter in World War I. Their organization has continued to grow because membership was opened to those bereaved mothers of subsequent wars, including World War II, the Korean conflict, Vietnam, the Gulf War, and the global War on Terror. The group's charter lists some of the organization's purposes, which include assisting patriotic work based on each member's dedication to the community, the state, and the nation; keeping alive the memory of those who died for their country in wars; assisting veterans and their dependents in working with the Department of Veterans Affairs; maintaining allegiance to the United States; and promoting peace and goodwill for the United States and other nations.

Gold Star Mothers are dedicated to turning the pain of their loss into a positive force to help others. These special women are annually recognized and honored in the United States. On September 14, 1940, President Franklin D. Roosevelt issued a proclamation designating the last Sunday in September as "Gold Star Mother's Day," a recognition that continues.

Robert G. Stevenson

See also Memorials; War Deaths

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Good Death

The good death is a difficult concept that has proven difficult to ignore. Would the wrong kind of death expose us to vengeance from the deceased spirit? Is self-termination the worst or the best kind of death? Should the health care system be expected to foster a good death for the nonresponsive person whose organs will soon be donated? Still haunted by ancient fears and hopes, the 21st century is adding its own technology-infused puzzlements. Both then and now, visions of the good death reveal much about the societies in which they have been constructed. The profusion and confusion of ways in which good death has been conceived are sorted out in this entry.

Good Dying or Good Death?

Often good death actually refers to good dying. Emphasis is on how a life ends, not on what might come thereafter. This orientation is at the core of the hospice/palliative care movement. People have varying beliefs about death and afterlife, but relief from pain and other symptoms would be welcomed by everybody. "Death with dignity" soon became a catchphrase, though the issue was quality of life during the final passage. Blurring the distinction can lead to miscommunication, when one person is focused on end-of-life experiences, and another on the nature and meaning of death.

Sometimes death does mean death. Devout people have suffered intense deathbed anxiety at the prospect of being judged unworthy. The memento mori ("Remember, you must die!") tradition that flourished in Europe from the 13th through the 16th centuries made the moment of death the final exam that determined the fate of one's soul. The outcome was uncertain. God's mercy might redeem a sinner, but a person regarded as pious and upright might be consigned to eternal damnation. The God-fearing person therefore prepared for divine judgment throughout life. The judgment of the dead had also been prominent in the dynastic Egyptian belief system, among others. Good death was the guiding vision in societies that envisioned the radically different outcomes of a blessed or tormented afterlife.

The distinction between dying and death would seem to parallel "alive" and "dead," but the increased use of life support systems has raised questions with medical, ethical, legal, and economic implications. Is the person in a persistent vegetative state dying, already dead, or suspended somewhere in between? Should termination be regarded as a good death that ends a bad dying? Or is this person's status now beyond dying-and-death, alive-or-dead, and good-and-bad? And perhaps beyond our ability to comprehend?

Euthanasia is a term frequently invoked in such a context. It is, laden, however, with ambiguity and emotional connotations. Euthanasia originally referred to an easy passage from life. The term can also be translated optimistically as "happy" or "pleasant." A person could be comforted by loved ones, priests, medications, and music, for example. The comfort theme has continued to the present day, but it was not long before euthanasia had morphed into mercy killing. On battlefields ancient and modern, a wounded warrior would be found in a desperate situation: helpless, mutilated beyond survival. His eyes, if not his voice, would speak for him. The warrior who found him—friend or foe—would end his suffering with a decisive blow.

Euthanasia became a questionable and highly challenged concept when the Nazis killed thousands of their own citizens who were institutionalized for various disabilities. These people were not dying, nor were they wracked with suffering. Nevertheless, their murders were described as euthanasia. This twisted exercise in mass killing served as rehearsal for the Holocaust, with its millions of victims. Understandably, euthanasia became linked with Nazi brutality. Responsible organizations that advocated improved care for the dying found it necessary to drop the term *euthanasia* from their titles. As the hospice movement emerged, it would encounter opposition based on fear that its hidden purpose was to terminate lives. Today, palliative care is better understood and the term *euthanasia* has been somewhat rehabilitated by subsequent responsible use.

Good death, then, can refer either to the best possible passage for a terminally ill person, or what the soul encounters when it has journeyed to "the unknown territory," as a prince of Denmark once observed. Both meanings are considered here,

focused on the question: What version of the good death do we prefer?

Perspectives and Preferences

Preferences are closely related to perspectives. Consider several perspectives from which preferences can be developed:

- An individual whose life will soon come to its close
- An individual whose health is not impaired and does not face a life-threatening condition
- Family and friends of a terminally ill person
- Caregivers of, and service providers to, a terminally ill person
- Society at large

Theoretically, people operating from all of these perspectives might share the same vision of the good death. In practice, however, differences are plentiful. Consider the following sample of perspective–preference links.

Society at large advocates the death that affirms its core values. The individual's final moments complete an ideal performance of the cultural script. Thomas More's *Utopia* (1519) offered an imaginary commonwealth as rational, efficient, and humane as the actual realms of the time were chaotic, bumbling, and brutal. The good death in Utopia occurred after a long life of service to the commonwealth. State-of-the-art comfort care was provided to the end. Nevertheless, some terminally ill people lingered in helplessness and discomfort. The authorities would then recommend self- or assisted termination. Those who agreeably terminated their lives would spare themselves suffering at the same time that they enacted a model exit. By contrast, the worst death was that of a person who dared self-terminate without official approval. Self-termination was lauded or condemned, depending on its accord with commonwealth values. The best of the good deaths occurred when the whole extended family turned out to be massacred in battle. The reasoning was that soldiers fight more fiercely when their families are also in danger. The family's willingness to expose itself to bloody death affirmed the all-for-the-commonwealth spirit. It is not only in Utopia that society prizes deaths that are interpreted as heroic or altruistic: A life that had not previously drawn attention can be honored as heroic if its ending strengthens a dominant cultural value.

There are also traditions in which deathbed transformations are held in the highest esteem. The deaths of some Christian saints are part of this tradition, as are the permutations of mortal into deity in ancient cults. In a different way, Zen masters have been admired for their ability to compose poetry with virtually the last breath. In Western society, memorable last words can leave the impression of a good death. An exceptional occurrence at the time of death can be regarded as the good transcending and validating all that has gone before and become inspiration for those who follow.

Caregivers and service providers in technologically developed nations typically are trained professionals, often specialists. Their primary mission is to keep people alive and functional as long as possible. Within this context, it is difficult to conceive of a good death: A fatal outcome can be experienced by caregivers as their failure. Physicians themselves observe that they withdraw from contact with dying patients because they recognize the limits of medicine's ability to thwart death. The best death is the one with the least notice, the least disruption in routine, the least fuss. Among the professional staff there may be little communication and less expression of grief. There may also be an implicit link with a fear that has permeated many traditional societies: The living are at risk from those who were wrongly dead or inadequately prepared for their afterlife journey. To ward off this hidden fear, modern physicians typically may insist on "doing everything" for the life-threatened patient, even if these interventions were painful, disabling, and inherently futile. "We did everything we could" does not necessarily make a death good, but it reduces the physician's emotional burden.

The palliative care movement challenges this approach. Comfort care is the priority when terminal decline and death are inevitable. Memories of the patient and family's gratitude for quality time together replace the stigma of medical failure.

Family and friends often are stressed by the medical procedures and surroundings, as well as by staff communications that do not seem to recognize their needs or answer their questions. From a family's standpoint, the good death

usually includes a trusting relationship with the professional caregivers, along with the feeling that their presence is welcomed. The average period of terminal decline has lengthened in recent years, so families often experience tension between the hope that their loved one will continue to survive and their exhaustion and stress from witnessing the decline over an extended period of time. "I want her to live" and "I don't want her to suffer any more: It makes me suffer, too" can be coexisting feelings. The "good death" occurs at what is experienced as the right time by family members and after having had adequate opportunity to be with, and take leave of, their dying loved one.

Healthy individuals typically are clear about what would not be a good death for them. Being maintained in a persistent vegetative state has become the most aversive prospect as reports of such conditions proliferate. What might be called "healthy dying" is the consensus choice for the good death. It should be symptom-free. No pain. No dependency. No helplessness. Nevertheless, the good death is not defined entirely by absence of negatives. Many people hope for the opportunity to end their lives at home with the companionship of loved ones. Some good death images include idiosyncratic elements, for example, listening to a particular song or revealing a long-held secret. Others emphasize maintaining personal control: "I will make the decisions. I will decide when it's time to go." By contrast, some express the serene wish that "I will be at peace with God and myself. That's all that really matters."

Individuals whose lives will soon come to a close often are restricted to the small world of disabled bodies, limited space, and routines of daily care. There can be refreshing moments of escapist fantasy, but the terminally ill person's outlook usually accords with reality. Most often, their wishes for the final days of their lives are simple, direct, and realistic, as, for example, "I want to be useful—somehow, to somebody—as long as possible." "I want the last few days of my life to be like any other." "I want certain people to be with me." "I want to feel at peace." The good death is the death one can manage with depleting energy, the death in which one can continue to be the same person, still in contact with the people and values that have long been cherished.

Appropriate Death

At issue is whether the physician, the health care administrator, the clergyperson, the lawmaker, or the scientist decrees what type of death is best. Pioneering existential psychoanalyst Avery D. Weisman has suggested otherwise. The appropriate death is the one that a person would choose for him- or herself if given the chance. Families, friends, and caregivers are most helpful when they understand and respect the terminally ill person as an individual, instead of relying on their own preexisting opinions. This concept must contend with all the others identified here, but perhaps offers useful perspective.

Robert Kastenbaum

See also Deathbed Scene; End-of-Life Decision Making; Euthanasia; Hospice, Contemporary; Organ and Tissue Donation and Transplantation; Persistent Vegetative State; Suicide

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Grave Robbing

Grave robbing refers to the desecration of graves in search of items of value. These items may be artifacts, objects, or human remains. Grave robbing stretches back to ancient times, and there are numerous examples of graves looted back into antiquity for the treasures that may have been deposited there. This entry focuses on the robbing of bodies from graves. It examines first the activities of the 18th- and 19th-century so-called body snatchers who were infamous for the theft of fresh corpses from their resting places. More controversially, the discussion then considers the removal of human remains from graves, as carried out by the archaeologists of that period.

The Essence of Grave Robbing

The use of the term *grave robbing* assumes a moral dimension to the removal of artifacts and bodies from graves and a collective condemnation of acts deemed, therefore, to be immoral. Yet, there is some debate and controversy surrounding acts that are considered to fall within the definition of "robbing" and those presumed to have a moral quality because they are conducted under the guise of modern science and of furthering knowledge. So, for example, archaeologists' removal of mummified bodies from the tombs of the ancient Egyptian pharaohs was generally perceived as an exciting enterprise that has furthered human knowledge about the nature of life and death in an ancient and sophisticated culture. Indeed, much of our knowledge and understanding of ancient and medieval cultures is based on artifacts found, throughout the centuries, in the tombs of the dead.

In contrast, the removal of whole, freshly buried corpses is roundly condemned as an immoral practice that desecrates graves and violates the people buried there. These acts were common in Western societies in the 18th and 19th centuries, particularly in the United Kingdom and the United States, when the body snatchers went in search of bodies that were to be sold to the expanding schools of anatomy and medicine. Although the bodies were to be used in the furtherance of science and medicine, the fact that they were taken without permission, sold for profit, and that their erstwhile owners were only recently dead, led to public moral outrage.

In this entry the work of the body snatchers, or "resurrectionists" as they became known, and also the more recent debates about the repatriation of remains collected by archaeologists are discussed.

The Body Snatchers

In the 19th century and still today, understandings of the nature of the self means that it is not possible to own a body and, therefore, dead bodies cannot be protected from theft under the law. Even though it is currently common practice for bereaved kin to be consulted on the method of disposal and to be asked for their permission to use body parts for organ transplantation, there is no legal requirement for this custom.

Although there were cases of bodies being robbed from graves prior to the 18th century, the proliferation of this practice in the late 18th and throughout the 19th century was largely a consequence of the quest for greater understanding of anatomy and the functioning of the human body, as well as of the nature of disease. Dissection had for centuries been viewed as a postmortem punishment for extreme crimes, and the bodies of executed murderers were the only ones legally available to the anatomy schools. The number of anatomy and medical schools in Western countries multiplied dramatically during this period, and this created an increased demand for cadavers that could not be met within the established provision of allowing them the bodies of executed felons. Other sources had to be found, and this led to a lucrative trade in the "snatching" (or robbing) of newly dead bodies from graves.

The theft of recently buried corpses was commonly considered abhorrent and the dissection of deceased loved ones horrifying, especially at a time when there remained a popular belief in the resurrection of the body—dissection by the anatomists and surgeons was assumed, therefore, to extinguish hopes of an afterlife.

Due to a paucity of legislation and the fact that there can be no legal ownership of a body, grave robbers could only be prosecuted for stealing objects from a grave and not for the theft of bodies. Although they were at risk of personal injury from the families of the deceased, to avoid criminal

prosecution the robbers would exhume the body, drag it out of the coffin and remove any items of jewelry or clothing (such as the shroud), placing these back in the grave before carrying the corpse to the dissecting room.

To protect the corpses of loved ones from the body snatchers, bereaved families would keep a night watch and to this end "watching huts" were erected in some churchyards to guard fresh graves. For those who could afford it, undertakers were able to provide fortified coffins and caskets, iron straps to hold the body securely, and iron railings to surround the grave.

The scandalous activities of the body snatchers were eventually to be curtailed by the introduction of legislation enacted as a consequence of a number of infamous incidents. In the United Kingdom the law was changed as a result of public outrage generated by the activities of William Burke and William Hare. Recognizing the lucrative nature of the sale of corpses to the medical schools, Burke and Hare decided to bypass the difficulties associated with removing fresh bodies from graves by murdering people in order to sell their corpses. The pair enticed people to the Edinburgh lodging house owned by Hare's wife and plied them with alcohol before asphyxiating them and selling their bodies to Dr. Knox at the Edinburgh School of Anatomy. They were finally caught and, in 1829, tried for murder after having dispatched 16 people in this manner.

In the United States, grave robbing was considered revolting by the general public, and its occurrence led to a number of riots between the years of 1765 and 1852. The most famous of these was the New York Doctors Riot of 1788, which was sparked by children observing anatomists at work in a laboratory in New York. Rioters burned down the laboratory, and seven people were killed in the ensuing violence. In 1789, as a direct consequence of the riot, New York passed a law that made grave robbing illegal but allowed the bodies of criminals to be available for dissection.

Legislation was also enacted in other U.S. states throughout the latter half of the 19th century but remained patchy until the early 20th century, by which time the majority of bodies used by the anatomy and medical schools were those left unclaimed by relatives. In the United Kingdom, disgust over the activities of Burke and Hare led to the introduction of the Warburton Anatomy Act of 1832. This act guaranteed an ample supply of corpses by allowing the surgeons and anatomists to use the bodies of unclaimed paupers who died in the hospitals or workhouses. Thus, if the previous legislation, which allowed the dissection of executed felons, was viewed as a punishment for crime, the new legislation might easily be perceived as a punishment for poverty, and the act gave the poor a further reason to fear entry into the workhouse.

The Archaeologists

The proliferation of body snatching in the 18th and 19th centuries was a consequence of growth during this period, of the quest for scientific knowledge. Alongside the anatomists' desire for greater understanding of the workings of the human body was a concern to learn more about human societies through the ages. The burgeoning discipline of archaeology was also involved in removing artifacts and bodies—long dead as opposed to fresh ones—from the grave.

Although not usually considered to be grave robbers, archaeologists have been accused by a number of indigenous community groups as having stolen bodies from the graves of their ancestors. This charge has led to demands for the repatriation of human remains currently lodged in museums in the West.

In the pursuit of knowledge and scholarship, early archaeologists frequently opened graves, removing artifacts, bones, and in some cases mummies. Perhaps the most notable case was that of the discovery of the pyramid of the young pharaoh, Tutankhamen, whose previously undisturbed tomb Howard Carter famously excavated in 1922, removing precious artifacts and the mummy of the king himself. The media images taken at the time show archaeologists carefully removing item after item of grave goods buried with the young pharaoh to assist him along his journey to the afterlife.

In some cases the opening and removal of items from graves may have resulted in the destruction of bodies and skeletons when the human remains were not perceived as being important or significant—for example, when the primary aim of the exercise was the sale of treasures to private or public collections. In other cases human remains were treated as objects, and their careful removal

was ensured so that they could be placed on public display in museums or traveling exhibitions. Indeed, many museums in Western countries such as the United States and the United Kingdom are replete with skeletons, bones, skulls, and mummies taken from ancestral graves.

The moral distinction between grave robbing and archaeological inquiry is founded on the perception of scholarship and the quest for knowledge that can only be attained by "digging up the past." It also rests on community and personal religious beliefs about the appropriate treatment of bodies, resurrection, and the nature of the afterlife. Thus, whereas scientists might argue that they need to retain human remains in museums in order to continue to generate knowledge about the lives of earlier peoples, many indigenous groups are now demanding repatriation of the remains of their ancestors. The latter are vehement that this practice is tantamount to an infringement of human rights.

One particularly interesting aspect of this discussion of the removal of bodies from graves is the degree to which the practice is perceived as an immoral act of theft according to the length of time since the burial. Thus, while preserved bodies found in shallow graves in the peat bogs of Ireland and Scandinavia might be viewed as an ethical source of information for scientists, recently dead corpses removed from the graves of countries in modern-day Europe and the Americas are not. To a large extent this distinction is due to the likelihood of there being surviving relatives and to shared religious belief systems, such as those within Christianity that assume deceased people should be allowed to "rest in peace" and not be disturbed in their graves.

There is also a cultural dimension, however, in that within Western societies time is an important factor. In many non-Western cultures time has little or no consequence for communities who believe that people are at one with the land and that their populations are linked, in an unbroken human chain, with their ancestors. Such is true of the Māori population of New Zealand on whose behalf a successful claim was made for the repatriation of two *toi moko* (tattooed heads) from the Perth Museum in Scotland. While the activities of the body snatchers were clearly immoral in that the theft and use of those corpses were against the wishes of both the deceased and the family, the issue for archaeologists and museum curators is whether the pursuit of scientific knowledge takes precedence over the cultural claims of indigenous peoples. The ultimate question here is that of whom the dead belong to.

Glennys Howarth

See also Cremation; Exhumation

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Green Burials

Green burials use environmentally friendly techniques to dispose of bodies and minimize the financial costs associated with funerals. In general, green burials require biodegradable coffins or shrouds if anything is used to cover the body at all. Burial sites are planted with native plants, grasses, and trees. Any practice or substance considered polluting or unnatural is discouraged. Allowing the body to decompose naturally while using as few resources as possible is the goal.

Green burials can take place at one's home, in conventional cemeteries that support such practices, or in green cemeteries. Green cemeteries require biodegradable substances to be used on and around the body; they do not allow embalming or vaults. Such graveyards create and maintain native plant ecologies. They do not use pesticides

or fertilizers. Aiming for a native habitat appearance, artificial markers such as engraved headstones are not permitted nor are lawns planted and maintained. Other terms used to describe green burials are *natural burials*, *woodland burials*, and *ecological burials*.

Green burials challenge the environmental costs of contemporary funeral practices. Conventional burials put toxic substances such as embalming fluid (which contains formaldehyde) and natural resources such as hardwoods, steel, copper, and bronze into the ground. Furthermore, the use of pesticides, fertilizers, and lawnmowers to maintain conventional cemeteries pollute soil, water sources, and air. Even cremation, a source of body removal that impacts the environment less than conventional burial practices, uses energy resources to incinerate bodies in addition to being a source of mercury and carbon emission. Although cremation can be used in green burials, it is considered less ecological than natural decomposition.

Green burials also confront the high costs of conventional burials. The National Funeral Directors Association estimates that the average cost of a funeral in the United States was $6,500 in 2004. This figure does not include payment for a cemetery plot or other cemetery fees.

History of Green Burial Movement

The contemporary green burial movement has its roots in the United Kingdom. Three psychotherapists—Nicholas Albery, Josefine Speyer, and Christianne Heal—founded the Natural Death Center in 1991. Inspired by the natural birth movement (with its emphasis on home births and family participation), Albery, Speyer, and Heal wondered if there was a more natural way to die than in a hospital surrounded by noise and machines or being embalmed and buried in suburban-style graveyards. The Natural Death Center provides information on how to arrange inexpensive, family-organized, and environmentally friendly funerals.

Ken West created the first natural burial ground in Carlisle, Cumbria, in the United Kingdom in 1993. The Carlisle burial ground aids conservation efforts by planting a locally grown oak tree on each grave. Family members are usually present at the tree planting. No gravestones or markers are used in the burial ground. Instead, names are placed on a wall at the perimeter of the woodland burial area. Such practices thus maintain local habitats and involve families in conservation efforts.

In 1994, the Natural Death Center started the Association of Natural Burial Grounds, an organization that promotes the creation and implementation of natural burial grounds. The United Kingdom movement highlights the use of burial grounds to create woodlands in part to conserve land in the face of continuing development. It has not, however, created standards of certification for burial grounds.

Contemporary Green Burials

The United Kingdom leads the natural burial movement with approximately 200 natural burial sites. The United States has the second most robust green burial movement. The first green cemetery in the United States was the Ramsey Creek Preserve, which is located in South Carolina and opened in 1996. Natural burial grounds also operate in New York, Maine, Texas, and Georgia, and more cemeteries are scheduled to open in the upcoming years.

To further promote and standardize green burial practices in the United States, the Green Burial Council, an independent, nonprofit organization, was created in 2005. The Green Burial Council works with funeral directors to increase options for green burials, certifies crematoriums that meet fuel efficiency and antipollution standards, and certifies green cemeteries. The organization has two categories of certification for cemeteries: conservation burial ground and natural burial ground. A conservation burial ground cemetery involves an established conservation partner and explicitly aims to promote land conservation. Conservation burial grounds use native plants and trees, biodegradable burial containers and shrouds, and living monuments (e.g., native trees) or rocks and boulders appropriate to the landscape, and they ban toxic chemicals and vaults. The natural burial ground category shares conservation burial grounds' use of native plants, living memorials, and toxic chemicals and vaults ban. This type of green cemetery, however, does not require partnership with an established conservation group or agency, nor does it mandate an explicit conservation goal.

Green burials have received positive coverage from mainstream and alternative news media and

popular culture. For example, the HBO television series *Six Feet Under* had Nate Fisher, one of the show's main characters, choose a natural burial in the fifth season. A funeral director by profession, Fisher rejects embalming and conventional cemeteries and opts for an environmentally friendly return to the earth. Poi Dog Pondering, a Chicago band, evokes the tenets of natural burials in their song "Bury Me Deep." The lyrics state, "Don't incinerate me or seal me from the dirt which bore me, the bed that which from the rain falls upon and the fruit comes from. For the dirt is a blanket, no fiery tomb."

Other countries are beginning to promote green burials and to form organizations that will support such endeavors. For example, the Natural Burial Cooperative, Inc., an organization that aims to develop green cemeteries across Canada, was formed in 2006. Italy, Australia, China, New Zealand, and other nations promote ecological alternatives to body disposal and are exploring the development of natural burial grounds. "People plantings," as Billy Campbell, the founder of Ramsey Creek Preserve, calls green burials, are desired by consumers worldwide.

Kelly A. Joyce

See also Cemeteries; Cemeteries, Ancient (Necropolises); Tombs and Mausoleums

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Grief, Bereavement, and Mourning in Cross-Cultural Perspective

Although death cannot be measured scientifically, the concept of culture provides the key medium for understanding the final boundary between our existence as living beings and the inevitable end of that existence. Death is a phenomenon of life, but consciousness of mortality is a social, not a biological, reality, because our knowledge about death and its meaning and value is socially constructed.

Most recent writings about grief and mourning are grounded on research conducted with subjects who live in North America and Western Europe. This research uses theories and methods that grew from the same geographical area and historical period. And although reports about mourning and grief come from many cultures, there is no accord among bereavement scholars about what concepts best explain the ways in which individuals and communities respond to death, grief, and mourning in different cultures. Exact definitions of culture are elusive, like the concept itself.

At the most general level, culture is defined as those aspects of human activity that are socially rather than genetically transmitted. Thus, culture consists of patterns of life passed among humans, which apply to every domain in society: religious beliefs, folk practices, language use, worldviews, and artistic expression.

History of the Concept of Culture

The origins of the concept of culture date back to the work of early post-Enlightenment folklorists who used the concept to avoid the uniform theories of human capabilities that were characteristic of the late 18th century. The modern concept of culture was developed later partly in response to racist and biological determinist ideologies of the 19th century, most of which incorporated an evolutionary framework based on social Darwinism. *Homo sapiens* was viewed as divided into separate subspecies or races, each with an essential characteristic, a system that included a hierarchy of moral worth.

Philosophers maintain that a general problem with the culture concept is that it is often linked with a naive relativism, precluding judgments about the unique cultural practices found around the world. In many cases practices dealing with death that were unsettling to Europeans, such as head hunting and ritual cannibalism, were the focus of disproportionate attention, supporting efforts to justify and document a radically different "other." The anthropological engagement with

mortality dates back to the origins of the discipline, and it is bound up with concerns about the origins of religion. Early theorists focused on small-scale societies where magic, science, and religion were not separate cultural domains. For example, the 19th-century anthropologist Edward Tyler, who worked from an evolutionary paradigm of explanation, viewed the origins of the human society and culture in efforts to explain mortality and, in particular, in the recurrence of dreams and other visions about deceased close kin. Social theorists influential to the development of anthropology, such as Émile Durkheim and, later, Robert Hertz, argued that all societies exert institutional controls to protect and preserve the life of the members, including rules governing appropriate and inappropriate killing.

Many actions that appear to be individual choices, such as suicide or the expression of the emotion during grieving, are actually socially patterned, as studies such as Durkheim's comparative analysis of suicide rates illustrates. Hertz used cross-cultural comparisons of mourning rituals to suggest that the human expression of grief can be understood also as a social fact, peculiar to each society. Scholars focused on the recurrence, throughout the world, of death ceremonies that expressed fertility and rebirth. The emphasis on sexuality, and the connection between sex and death, fit well with interpretations of ritual behavior that emphasized function. Death rituals serve the function of reintegration of society following a death, focusing on reproduction.

In some societies this symbolic link between death and regeneration is expressed explicitly; for example, some funerary practices incorporate the abandonment of usual standards of sexual propriety for a confined time period, or allow and encourage sexual relationship between categories of kin where such contact is generally excluded. These rites of passage seem designed to guide the passage of humans through dangerous, liminal transitions, marking the boundary between life and death—hence the association between funerals and other rites of transition such as initiation ceremonies.

In contemporary Western society, the practices of bioethics developed in the past several decades have become the new rituals guiding the transition between life and death. A number of studies in anthropology and medical sociology offer accounts of the disclosure of a terminal diagnosis to children under treatment for leukemia. One such example is David Sudnow's account of dying in a public hospital.

Grief and Mourning as Instinctual Responses

From a biological perspective it appears that grief is a universal phenomenon. In every culture people cry or seem to want to cry after the death of someone who is significant to them. Grief, therefore, could be envisioned as an instinctual response, shaped by evolutionary development. Many species of animals perhaps grieve. Birds, dogs, and primates display behaviors that seem equivalent to human beings in reply to separation and death. Instinctual reaction in this sense is a meta-interpretative scheme programmed into our genetic inheritance. The response is aroused by the perception of distinct situations (e.g., damage, success or failure, education opportunities).

Culture, indeed, influences how people evaluate situations, and similar perceptions of events trigger similar instinctual responses. A significant death, then, might be regarded as a universal impulse of grieving emotions, although which death is significant enough to spark such a response depends on the value system of a particular culture.

Universal Instinct Theory

The theoretical emphasis on universal instincts has generated a large body of research and practical findings useful to clinical practitioners. In universal instinct theory, a significant death causes a response much like that which a child feels upon separation from the mother. In the beginning the child protests and makes an attempt to get back to the mother; soon afterward the child despairs of returning to the mother but remains preoccupied with her. Grief after a significant death follows the same preprogrammed sequence of behaviors.

Attachment

Attachment is an instinctual behavior that has survival value because it keeps the child close to the mother for protection from predators. Human beings are attached to individuals all through their

lives, and when they die, individuals experience separation and loss and so must reorganize their attachments to match the new reality. Some recent grief research suggests that attachment styles in childhood predict bereavement style in adulthood. Contemporary attachment theorists have asserted that attachment is biological and, though influenced by culture, still functions similarly in all cultures. Furthermore, the template used in attachment bereavement theory is the reaction of young children when separated from their mothers.

Grief

In grief, the theory holds, adults are all like children, looking for reunion with the departed person. The theory does not recognize that as people mature, their attachments become broader.

The young child perceives his existence only in relationship with the mother. As the child matures, each level of social membership or identity is also an attachment such as to the social group, community, tribe, nation, and religious tradition. At each level, separation becomes a less probable explanation for grief because attachments to individual people become embodied with social systems and cultural meanings that cannot be narrowed to biological heritage.

In the individualistic culture of modern Western world, with its destroying attachments to larger social systems, primary social relationships are restricted to the nuclear family. Such individualistic relationships resemble but do not duplicate the genuine mother-and-child bond. Death may arouse instinctual responses other than those that are marked "grief." In Western culture, for example, this arousal may be a trauma response.

It may also be that the trauma reaction is as universal as the separation reaction in attachment.

Trauma and loss are different meta-interpretative schemes. In the Western society some deaths are traumatic, some traumas are not connected with death, and some deaths are not traumatic. In modern Western culture, rape evokes a response close to that of a traumatic death. Other cultures may have meta-interpretative schemes that can be related to death (revenge, submission, and purification) but may not be pertinent to the modern Western culture. In traditional Chinese culture, for example, grief is interfaced with the problem of pollution.

One of the purposes of the funeral rituals was to protect men from pollution while women took the pollution on themselves, thereby purifying the deceased for the afterlife. Death presents pollution or powerlessness in some cultural contexts as much as it presents separation, loss, and sometimes trauma in the modern Western society.

Cross-Cultural Instinctual Theory

As researchers develop a cross-cultural theory of instincts, they will cast their attention to other instincts much as they have given to attachment and trauma. At a symbolic and metaphoric level, death is used to understand other realities in human existence. One way to find the instincts evoked by death might be to consider a culture's use of death as a metaphor. For traditional Chinese women, death was like marriage, encompassing mutual obligations between the living and the dead. In the West the concept of grief is applied to other separations and losses, such as divorce, and to other traumas, such as home invasion.

All people are shaped, to some extent, by the culture into which they are born and raised. The human expression of grief is no less a product of culture than are marital or religious customs or symbols. How individuals and families cope with dying, death, grief, loss, and bereavement is as unique as a fingerprint. The reaction to the death of a family member, relative, or close friend places one in the category of *bereaved*. Those who are bereaved experience *grief*, a person's response to loss, which encompasses physical, psychological, social, and spiritual components.

How one copes with other life events and adapts to one's present and future is also part of the grieving process. A public ritual such as a funeral or memorial can offer powerful closure for those suffering traumatic grief. The conclusion of grief often includes cultivating bonds of emotion and meaning with the dead. People who are important to us become part of our inner conversation and remain there after they die. They may continue to play important roles in our lives and inside the community for many years after they have died.

Throughout history this particular persistent communion with the dead has been a recurring behavioral pattern, far more common than an outright severing of all bonds. Western psychologists

became interested in individual grief—the ways in which survivors live on after a death—precisely at the time when the cultural narrative about afterlife had begun to wane.

Continuing bonds with the dead in individuals and families became integrated into the collective representation that mediates the culture to the individual.

Durkheim affirmed that collective representations play a major role in developing social solidarity and identity in tribes, ethnic groups, and nations. Grief and the ceremonies of mourning place the dead into collective memory as well as into the individual memories of those who knew them. The memory of soldiers who die in war, for example, is evoked during patriotic celebrations in every culture. In Chinese ancestor rituals, the dead remain part of the family, defining the values by which the family lives and creating the shared identity of the living members of the family.

The memories of martyrs energize living people who believe in the ideas or causes for which they died.

Grief and the Boundary Between Life and Death

The concept of "social death" has been of remarkable utility in describing the varied boundaries between life and death throughout the world, and it is intimately tied up with notions of self and who counts as a person within a society. Scientists observe and document societies in which full-term infants are not considered fully alive, and thus not considered members of the social group, until they have survived the first month of life (perhaps not by chance the period of highest vulnerability for newborn) and received a name in a formal naming ceremony. Those who die before naming are not considered fully human and thus do not warrant ritual attention, such as funerals or elaborate mourning rituals.

Such practices are in sharp contrast with contemporary obstetrics practices in the first world, where developing fetuses are named and ultrasound images are exchanged prior to birth.

Indeed, the survival of extremely premature infants in neonatal intensive care units is best understood as an artifact of culture. In other societies, specific kinds of births (such as twins) or certain infants (such as albinos) may be judged as incompatible with life and thus viewed as already dead or vulnerable to infanticide. In Bariba African society certain infants are understood to be witches, and thus mothers are not allowed to grieve the loss because the infant is defined as not human and potentially dangerous for the entire community.

All societies have rules about how emotions of grief are to be displayed and handled. For example, a common way in the West of dealing with grief is to talk about one's experience, one's relationship with the deceased, and one's feelings. But in some cultures, talking may disrupt hard-earned efforts to feel what is appropriate, and to disrupt these efforts may jeopardize one's health. In some cultures, talk is acceptable, but one must never mention the name of the deceased person. In other cultures talk is admissible as long as it does not focus on oneself. Even in Western society, however, not everyone is open to talking.

It is important, however, not to consider those individuals who do not openly express their emotions as pathological. In fact, the idea of pathological grief is primarily a Western construction; in other cultures the labels would be different but with a common purpose: conforming people to the social rules. There is enormous variation in what is considered appropriate behavior following death. The ideal among traditional Navajo is to express no emotion, while in tribal societies a death may be met with outpourings of grief, including self-mutilation.

In contrast to clinical notions of pathological grief, in some Mediterranean societies widowhood was considered a permanent state of mourning, and mourning clothes were worn for years, if not decades. In a recent compelling book titled *Consuming Grief,* Beth Conklin describes how a South American native population, as well as a Papua tribe, assuage their grief by consuming the body of their dead kin.

In some traditional societies, to avoid being a burden to the wider community, elders choose to end their own lives by exposing their bodies to the elements; the perhaps apocryphal Eskimo on an ice floe provides a powerful image whether or not supported by the ethnographic evidence. Or mothers may withdraw their attention from a child deemed unlikely to survive in an exhausted environment like the slums of northeastern India. The

Wari native inhabitants of the Amazon respect their dead, and relieve their grief, by participating in ritual mortuary cannibalism.

It is helpful to consider how taking an anthropological or cultural approach to the study of grief differs from the approaches taken within philosophy, where the mystery of death has been a topic of speculation and discussion for thousands of years. Philosophy has attempted to account for death conceptually: Death is a state following upon the end of life; it is the absence of life. By contrast, cultural critiques begin with a set of social issues that move beyond the individual to focus on how different societies manage the existential fact that all members will eventually die and on the practical implications of the death of individuals, including the reintegration of survivors of a death. Ethnographers, anthropologists, sociologists, whether studying tribal and hunter-gatherer societies or contemporary intensive care units, have a quite different task: describing the range of culturally patterned responses to the existential realities of eventual human frailty and death.

The Importance of Afterlife in Cross-Cultural Perspective of Grief

The fear of death and the belief of life after death are universal phenomena. Human consciousness cannot have access to one's own death as an inner experience because death is an inevitable personal experience, which remains outside of individual self-reflection during a lifetime. However, throughout their lives human beings may be witness to several deaths, for the quest of the survivors after the substance of death follows the same cognitive scheme as when they think about the substance of their own mortality. Whenever we imagine ourselves as dead, we are as present in the picture as those who do the imagining; our living consciousness looks at our dead bodies. Therefore, when speaking about the cognitive ambivalence of death, there is the simultaneous presence of the feeling of uncertainty emerging from the taboo character of death and the knowledge of its ineluctability.

This constellation normally constitutes a powerful source of anxiety. To reduce the anxiety emerging from the ambivalence of death, every culture engages in anthropomorphizing. The essence of this mechanism is that individuals perceive death and afterlife on the pattern of their life in this world, by the projection of their anthropomorphic categories and relations.

Anthropomorphizing the ideas concerning the other world, the process called secularization, is present in all religious teachings with greater or less intensity. It can also be found in folk belief systems that are not connected to a church or religious issues. According to the members of the European peasant communities, for example, the surviving substance generally crosses a narrow bridge over a river to reach the other world. The most widespread idea is that of a world analogous to ours but more pleasant and of a society organized in the same way as it is on earth.

Anna Maria Destro

See also Awareness of Death in Open and Closed Contexts; Communicating With the Dead; Death, Philosophical Perspectives; Grief, Types of; Memorials

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Grief, Bereavement, and Mourning in Historical Perspective

The common root of the words *bereavement* and *grief* is derived from the Old English word *reafian*—to plunder, spoil, or rob—which gave name to the *reavers*, bands of murdering bandits who terrified the uncertain lands between England and Scotland. Thus the root of the words *bereavement* and *grief* designates abrupt, violent deprivation with the resultant loss typically involving the soothing or cheering reaction of the soul. These two aspects of loss by death—the sense of

personal violation and the heaviness of the soul—are thus enclosed in the language itself.

The clinical study of reactions to loss began in the early years of the 20th century with the publication of Sigmund Freud's 1917 classic essay "Mourning and Melancholia," in which Freud includes the behavioral and emotional changes that are set in motion after a significant death under the single term *mourning*. The term has been used to cover the wide variety of reactions to loss and later to affirm that there is a difference between grief and mourning. Thus mourning is described as a public act of expressing grief that is culturally determined and distinguishable from individual spontaneous responses.

Another important theoretical approach acknowledges that both grief and mourning are subject to considerable modification, depending on the history and circumstances of the bereaved. Thus mourning is the conventional behavior, determined by the habits and customs of the society, whereas grief is a set of stereotyped responses, psychological and physiological, of biological origin. In contemporary thinking, this distinction continues to be assumed.

Finally, brief definitions of the key concepts can be offered: bereavement, the loss of a significant person in one's life, which characteristically generates a reaction we call grief, which is evident in a set of behaviors we call mourning. Grief has been described as mental pain, distress, and deep or violent sorrow associated with bitter feelings of regret for something lost. Mourning, on the other hand, has two aspects: one subjective and rooted in anxiety, fastening, remembrance, dying, and withering, and the other in the public expression of grief and the exhibiting of conventional or ceremonial signs of grief such as wearing the appropriate garments or respecting pertinent social traditions. Many theorists, then, have indicated that while loss and grief are universal in humans and present, to some extent, in certain other species, mourning is culturally determined.

The Early History of Grief, Mourning, and Bereavement

Although a sense of loss, and therefore grief, may extend back at least to the time when the first anthropoids were recognizable as human, it is only in relatively recent years and in some societies that entire industries have grown up around death and its aftermath. Many primordial myths contain the idea of a golden age before the existence of death, and suggest that it was called into being by some mistake or to keep humankind from challenging the gods. Ancient stories and legends also speak of the struggle humankind has long been engaged in to come to terms with the finality of death and to deal with its aftermath in individuals and societies.

Early writings inform us that bereavement was known as a source of physical and mental disturbance in those left to mourn. In one of the earliest known poems in the English language, "The Wanderer" (ca. 850 C.E.), the poet mourns "Here possessions are fleeting, here friends are fleeting, here man is fleeting, the kinsman is fleeting . . . the whole world become a wilderness." In the early Greek myths, when the goddess Demeter loses her daughter Persephone, she loses "her gaiety for ever." Demeter shows the characteristic restlessness and emotional turmoil of acute grief: She seeks her child for 9 days and nights without rest, food, or drink, and when she hears that Hades (death) has taken her, she is so angry that she is ready to destroy everything living on earth. The desolation, restlessness, and raging against death shown in these ancient legends are familiar to us today. Now, at the beginning of the 21st century, the methods of inquiry and the core of interest may be new, but the struggle to make sense of death goes on essentially unchanged. To outline the historical perspective of grief, we must investigate the origins of that struggle.

Burial Activities

Knowledge of the behavior of our early ancestors, due to the absence of written records, is necessarily speculative, based as it is on the placing and types of ancient fragments, natural and manufactured, of their lives. We know that, at some point, probably between 50,000 and 80,000 years ago, human remains began to be buried or disposed of in a deliberate and sometimes ritualistic way. The adoption of these practices has delineated the transition from savagery to barbarism in coincidence with archaeological confirmation of significant changes in the economy of hunting groups. The

change from simply leaving a corpse for the natural processes of decomposition and predators to deal with, to undertaking the group effort of burial, is considerable. At the very least it indicates a concern with things other than immediate survival.

Burial has become a symbolic act; it can thus be regarded as a social act also, of significant value for the group. There is no basic biological reason for humans to have expended time and energy, that might otherwise have been devoted to the acquisition of food, to the burial of the dead. It appears to have been selective; that is, not everyone was accorded burial. Grave goods have been found in some very early tombs and, although it has been argued that on some sites the placement was accidental, there are instances of flint knives placed in the hands of corpses.

Other evidence of symbolism includes red ochre having been strewn on the body, placement on a bed of seashells, crowns of goat horns around the head, animal skulls in the corpse's hands.

Even if we cannot know the precise intentions of those who buried their dead in such a way, we may deduce that they continued to care for that member of their group even after death as they protected the body. They also kept the body close by: Intentional burials are associated with dwelling sites, and available evidence suggests that care of the body and the implication of thinking about its disposal were important. The evidence collected from these early burials may be taken to imply the capacity to imagine, to have a sense of an "other" which cannot be seen or experienced directly, and to acquire a consciousness of the future.

Death as a Basic Social-Cultural Concept

Homo sapiens developed the competence for symbolic thought, and along with this capacity emerged ideas of the journey associated with death, of leaving the body when it died, and continuing existence in another form, elsewhere. But, as larger social groups formed and increased in number, after the progression of an agrarian economy and the expanding use of tools, the ritualistic disposal continued to be selective and became more elaborate.

There are many indications of religious formalities, such as burial hills positioned to the rising sun and sacrificial marks on or near some grave areas. Thus it appears that from our earliest days there have been rituals concerned with death that were important enough to involve the community in hard physical work implying continuation elsewhere, as the notion of a spirit or soul released from the body to journey on.

These two aspects of funeral rites—messages about the strength of the ongoing group and its configuration and messages about the change death has made to the individual member, who is now elsewhere—are universal. These are expressed in many different ways across cultures and throughout history, and a great number of religious convictions are associated with them and the fate of the soul. In ancient Egypt pharaonic tombs became so complex that they had to be planned well in advance of the death of the pharaoh. The pyramids were expensive in terms of working hours, materials, and lives of the workers. The bodies of those high in social position were preserved by mummification and buried with expensive grave goods, but nobody knows what happened to the bodies of the common citizens, the poor, or the slaves. In early China, for example, members of the household of a high-standing personage were sometimes murdered on the occasion of his or her death and buried in a huge tomb with their lord or lady.

In Northern Europe, Viking heroes and kings were buried in ships filled with food, jewelry, and weapons to ensure the dead would have all that was necessary for life after death. Wives, mistresses, horses, and dogs were killed and laid to rest with the deceased Viking. The ships were covered with mounds of soil or set afire and let sailing off the coast. These historical facts say nothing directly about personal grief; they only reveal its public face. But these facts are important, based as they are on the treatment accorded to dead bodies.

From History to Early Philosophers, Understanding Grief

For both humankind generally and each living person individually, the recognition of the universality and inevitability of death is but the beginning of the problem of death. Indeed, recognizing death as the individual and collective fate of human beings, and of all living creatures, creates the problem of death: Why does it happen? What does it mean? Is death final? As such questions emerge, so do other issues that are provoked by death: What is the

meaning of life, its purpose? Can life be meaningful if it ends in death?

Philosophers have struggled with the human fear of death, trying to alleviate grief and mourning. Recognizing the inevitability of death is very different from supposing death is final.

At a very general level, philosophical and anthropological reflections on death divide those who deny the finality of death and suppose there is ongoing, usually individual, self-consciousness after death, and those who regard bodily death as final, as the destruction of consciousness, but who offer consolation meant to assuage fear of the inevitability of personal extinction. A few philosophers have found death to be inevitable, final, and horrible.

What binds together in a recognizably Western tradition are the analytical approaches each group takes and the exclusively human-centered character of their views. Probably the single most persistent theme in Western reflection on death is the view that death is not the annihilation of the self but its transformation into another form of existence.

The conviction that individual human beings survive death, perhaps eternally, has been very differently grounded and elaborated in the history of mankind, but in some form it has persisted and frequently dominated through antiquity, the long era of Christian theologizing, modernity, and into contemporary postmodern thinking.

Considerably less attended to is the attempt to reconcile human beings to death's finality, to death as the end of individual human experience beyond which there exists no consciousness.

The tension in Western society between regarding death as transformation and thinking of death as final appears, at the very outset of what conventionally is regarded as the beginning of Western philosophy, in the fragmentary remains of writing that have survived from thinkers in the early Greek colonies of Asia Minor, especially the Ionians.

The attempt to reconcile opposites, such as life and death, and to perceive the underlying unity, even harmony, in all of reality was preeminent for the pre-Socratics. Anaximander (ca. 610–547 B.C.E.) and Heraclitus (533–475 B.C.E.) were singularly impressed with the transitoriness of all things, as captured in the best-known corruption of a Heraclitean fragment, "One cannot step into the same river twice." The earliest surviving pre-Socratic fragment, from a document attributed to Anaximander, contains the evidence of how impressed he was with the terrible fact that things perish but also expresses the hope "that somewhere and somehow death shall have no dominion." Despite the appearances, death is not annihilation: In the everlasting boundlessness (*apeiron*), individual death is not meaningless, perhaps not even final.

In southern Italy, Pythagoras (ca. 572–497 B.C.E.) struggled with the same realities, teaching that the soul suffered from embodiment, longed for release and reunion with the divine (possibly as death experienced transmigration into other life forms), and could be partially purified through the process of rebirth. For the purification needed to overcome death and to be evermore united with the divine, it was most important to live a philosophical life, especially one that paid considerable attention to the contemplation of mathematical truth. Permanence and impermanence, constancy through flux, continuity and change, death, extinction and recurrence are the enduring concerns of pre-Socratic scientists.

Socrates' (ca. 470–399 B.C.E.) view of death seems to be rooted in the immediacy of his experience and circumstances, at a time when he is first anticipating, then under, a death sentence. More than the words that Plato and Xenophon report him to have said, it is the moral lesson Socrates sets that has influenced entire generations.

Indeed, the art of mastering the fear of death is not easily learned. Stoics recommend emulating great men, virtuously living the life of the philosopher, and always recalling that living well is by far the most important thing along with documented reminders of the futility of fearing or resisting death.

Grief and Mourning at Medieval Time

During the medieval era, death was a constant presence and dance, like other forms of art, has considered the matter of death throughout history. Rituals have surrounded the mystery of death from prehistoric times, and the reiterated rhythmic movements become dance, in some cases endowed with a therapeutic sense.

Funeral processions are an example of organized movement to music, expressive of grief. The *danse macabre* (*Totentanz* or "dance of death") of

the European Middle Ages was represented many times on the walls of cloistered cemeteries as a dance of linked hands between people of all levels of society and the skeletal figure of death. These painted images were performed in a period of affliction and fear caused by the bubonic plague, which swept the entire continent, murdering a large portion of the population.

The earliest known appearances of the danse macabre were in story poems that reported of encounters between the living and the dead. Usually the living were knights, bishops, or distinguished members of the society. The dead interrupted their procession saying that as they were, the living shall be, underlying the theme of the uncertain human fate. Neither strength nor piety can provide escape.

The danse macabre portrayed on the cloister walls of the Innocent cemetery in Paris no longer exists, but there are wood copies that represent the first haunting visual image. The picture contains four skeletons performing on bagpipe, harp, organ, and small drum. The dancers seem to move in a low, stately procession clearly resembling a ritualistic rather than a social dance, where all the players are following their leader: Death. During the plague (black death) years of the 14th century the danse macabre made its first appearance and became an increasingly familiar cultural element all over Europe: In Germany it was called *Totentanz*, in England *dance of death*, in Italy *danza della morte*.

Of the various explanations of the origin of the term *macabre*, perhaps the best-founded was that offered by the historian Philippe Ariès. He observed that the Maccabees of the biblical period were considered and venerated as patrons of the dead. Over the years the word *Maccabee* became a popular expression for the dead body, and Ariès found that the term still had that meaning in the folk slang of the late 20th century. The fearful images attended several purposes, to include assisting and encouraging people to manifest and share their grief; to remember that death is not only unavoidable but also the great equalizer, calling the high and the mighty as well as the humble; and to provide the opportunity for indirect control. When vulnerable mortals could paint, describe, and perform the danse macabre, they earn a subtle but perceptible sense of control. To overcome the sorrow of grief, the figure of Death was also increasingly subject to caricature. The strong human imagination had made Death a character, often honored, sometimes frightening, and, eventually, even comic.

Ars Moriendi

Ars moriendi, or the art of dying, as a body of literature provided practical advice for the dying and those attending them. By 1400 the Christian tradition had well-established beliefs and practices regarding death, dying, and the afterlife. The ars moriendi packaged many of these into a new brief format. The first such work appeared in Europe during the early 15th century, and forms of this writing lasted well into the 18th century. These manuals informed the dying about what to expect and prescribed prayers, actions, and attitudes that would lead to a "good death" and salvation.

During the previous century the black death had devastated Europe, and its reappearances (along with other diseases) continued to cut life short. The Hundred Years War between France and England was the era's largest conflict and the fragility of life under these conditions coincided with a religious shift, whereas the early Middle Ages accentuated humanity's collective judgment at the end of time; by the 15th century, attention focused on individual judgment immediately following death. Individual death and judgment thus became urgent issues that required preparation.

To meet this need, the ars moriendi emerged as an educational program to prepare priests and common people to face the social consequences of mourning and bereavement.

The Contemporary Experience

Considering the documented evidence from the Middle Ages to the present, historian Ariès has discovered a cardinal switch in behavior. Where death had once been familiar and "tamed," it was now untamed, "forbidden," and even, as Baudrillard said later, "pornographic." Medieval people accepted death as a part of life: Death was expected, anticipated, and consequently more controlled through rituals. Rural folk, in Western society, maintained such attitudes until the early 20th century,

The rise of modern science and the development of medicine led society to challenge beliefs in divine judgment, in heaven and hell, and in the

necessity of dying in the presence of a priest. Attention fell on the emotional pain of separation and on keeping the dead alive in memory. With each new attitude, Western Europeans distanced themselves from the old ways. Contemporary historians attribute the causes of change, even in collective attitudes, in more objective measures.

Anna Maria Destro

See also Ariès's Social History of Death; Art of Dying, The (*Ars Moriendi*); Dance of Death (*Danse Macabre*); Death, Philosophical Perspectives; Good Death; Grief, Bereavement, and Mourning in Cross-Cultural Perspective

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Grief, Types of

As social beings, our need to attach to others begins at the time of birth. In fact, our survival depends on meeting this need. Ongoing cultivation of this need leads to many significant relationships during our lifetime. However, when a loved one, to whom we had attached in a variety of ways, dies, it is often a devastating experience. A process of adjusting to this experience of loss is what psychologists label as a bereavement crisis. In Greek, crisis means turning point. During this turning point in our lives after losing a loved one, the intense emotional experience is called grief. Loss and grief go hand in hand and grief as a universal experience is a part of every person's life. Change in circumstances after the death of a loved one, difficulty in functioning as one had functioned before the death, and having to accept the unacceptable give rise to a multifaceted grief reaction. Even though it is a sad and painful experience, grieving is considered a necessary part of post-death adjustment. While no one is spared the challenge of dealing with loss and grief, the differences lie in the type and duration of grief experienced and how people cope with their losses.

Many experts have tried to explain the normal experience of grief in a variety of ways. Some explain grief by breaking down its course and components into stages or phases, while others describe tasks of mourning. These models of grief provide the frame of reference for the bereaved to conceptualize their experience of loss and its resolution. Regardless of the conceptual differences, a common theme in all these theories is that grief is a process and not a static event.

One of the original and best-known theories of grief is presented by Elisabeth Kübler-Ross. She identified five stages: denial, anger, bargaining, depression, and acceptance. This theory is applicable to both the patient who has been diagnosed with terminal illness as well as his or her family members. Following Kübler-Ross, many writers have presented their grief models with different numbers of stages or phases. A more simplified and inclusive view based on these models is that generally people tend to pass through three broad phases or stages of bereavement. These stages overlap and do not necessarily occur in a sequence. In fact, the bereaved individuals move back and forth between these stages as they work through them. And not everyone goes through these stages at the same rate and with same intensity.

An initial stage of shock, numbness, or disbelief is characterized by mechanical functioning and social insulation. This phase may last for minutes or weeks. The next stage of depression incorporates acute anguish with intensely painful feelings of loss that usually lasts from weeks to months. Finally, after months or even years, a phase of resolution involving reentry into a somewhat "normal" social life arrives. During this phase, the reality of the loss is accepted and intensity of grief symptoms diminishes. The grieving person begins to focus on the present and the future. An identity without the deceased is established and life can be enjoyed again. However, a normal progression through these phases or stages depends on a person's personality, type and nature of the relationship with the deceased, past experiences with losses, his or her present life circumstances, circumstances and nature of the death, and existing support system. Although people may successfully proceed through various stages or phases of bereavement, their perception of loss may always be there.

Along with understanding the progression of stages of grief, it is also helpful to understand different tasks the bereaved must perform to reach a satisfactory resolution of the bereavement process. To empower the bereaved, who are perceived to be not just passively passing through certain stages, J. William Worden proposed an action-oriented approach, which complements the stage theory and which consists of four tasks of mourning: (1) acceptance of the reality of loss, (2) working through the pain of grief, (3) adjustment to the environment in which the deceased is missing, and (4) emotional relocation of the deceased and moving on with life. Through these tasks, one works through various aspects of the bereavement process to achieve its completion and subsequent equilibrium. All theories of bereavement are focused on (a) helping the bereaved acknowledge their grief resulting from a loss, (b) understanding that it is normal to experience a variety of dysphoric physical and emotional symptoms, (c) directing the bereaved to attend to "grief work" because successful grief resolution is not automatic, and (d) knowing that the bereavement journey has a final destination of acceptance and moving on with life.

Symptoms of Grief

Grief is manifested in a variety of symptoms, such as disbelief; shock; numbness and feelings of unreality; anger; guilt; sadness; periodic crying; preoccupation with the deceased; sleep disturbance; difficulty in concentrating on tasks; loss of appetite; weight loss; loss of interest in other people and activities; lack of energy; irrational hostile feelings directed toward the deceased, God, or someone else; intense yearning for the deceased; and smelling, seeing, or hearing the deceased. This is not an exhaustive list of symptoms. In fact, there is no complete list of symptoms of grief and they vary from person to person and situation to situation. Many symptoms of grief are similar to those experienced by persons with psychological disorders and are generally classified into four categories: affective, somatic, cognitive, and behavioral symptoms. The intensity and duration of grief depends on a variety of individual and situational factors unique to each individual's bereavement process. Important factors determining the intensity and duration of grief are one's level of attachment to the deceased, circumstances of death, nature of the death, and the personality makeup of the bereaved. Notwithstanding, it is normal for people to experience any range of dysphoric reactions.

Unlike in the past, grieving in this contemporary age is expected to be done expeditiously. One is expected to be at work a few days after a death occurs and to resume the level of productivity one had had prior to the death. Mourning is somewhat limited to the time of funeral. This is again unlike the past when many postdeath rituals and customs were observed and served to make people around the bereaved more sensitive to the distress and needs of the grieving.

Normal Grief

In the course of the normal grieving process, the grief symptoms gradually reduce and the bereaved person begins to accept the loss and to readjust. Some of the symptoms may return briefly on death anniversaries, birthdays, or other important occasions related to the deceased; this return of symptoms is considered normal. It is generally agreed that the average period of time for normal grief in American society lasts from approximately 12 to 18 months. If one's grief-related behaviors continue beyond this time frame, the grief may be considered unresolved, complicated, or pathological. However, in certain losses such as loss of a child, this process may be expected to last 4 or more years. Usually if the grieving process continues in high intensity beyond the culturally defined mourning period, it may lead to clinical depression. About one in five bereaved individuals are eventually diagnosed with major depression. Individuals at highest risk for major depression are those with prior episodes of depression, with alcohol- or drug-related problems, without an adequate support system, and/or concurrently facing other major life stressors.

Anticipatory Grief

Normally, the bereavement progresses from denial to acceptance in a culturally prescribed manner, except when someone has a terminal illness or develops a debilitating disease, such as Alzheimer's, that robs him or her of faculties. The initial phases

of bereavement are experienced by the family and friends in advance before the death. This kind of grief is called anticipatory grief. Family's protectiveness, overinvolvement, and unresolved issues may complicate the grieving process for both the patient and the family. The family members may experience conflicting emotions due to the prolonged nature of the crisis. On one hand, they dread the death of the loved one; on the other hand, they hope for closure and an end to the crisis. They may feel anger with the loved one for becoming ill and wish for deliverance from the burdens of caregiving, and then later be consumed with the guilt of having such thoughts. Tremendous strain is often experienced due to the prolonged illness and waiting for death, which can be emotionally and physically exhausting.

The dying patient's anticipatory grief has two components: anticipating his or her own death and feeling responsible for the burdens and sadness of loved ones caused by the impending death. While the anticipation of death or profound decline of mental or physical health is very disruptive, it can be beneficial as well, because it cushions people to absorb the loss and complete unfinished business. The patient and the loved ones have time to prepare for death and say good-byes. However, anticipatory grief does not replace the grief felt after the death. In fact, the bereavement process cannot be completed until after the death, even though many tasks of bereavement are completed while waiting for the death to occur.

Disenfranchised Grief

Sometimes people experience losses that are not considered significant, socially recognized, or publicly mourned. Such losses lead to what is called disenfranchised grief. Some examples of situations when disenfranchised grief may occur are aborted or miscarried pregnancy; stillbirth; disappearance of a loved one; death from AIDS; death of someone with whom the relationship is not sanctioned or recognized by the society, such as same-sex partners or extramarital lovers; or a past relationship, such as an old boyfriend or an ex-spouse. The disenfranchised grief may also be experienced by those who are considered incapable of grieving, such as persons with developmental disabilities or children. This kind of grief can also create problems in the workplace. Because of the limited opportunities to formally express the feelings of grief in nontraditional losses, disenfranchised grief often takes longer to resolve than the grief due to traditional losses such as losing a parent, spouse, child, or friend. The bereaved also may require professional help to complete the bereavement process.

Complicated Grief

All cultures contain normative expectations pertaining to normal grief reactions. These expectations are represented by the types of clothing, bereavement rituals, mourning behaviors, and acceptable length of time for mourning. Failure to meet one's cultural expectations for bereavement and mourning is often labeled as complicated, unresolved, or pathological grief. Grief can also become complicated if the progression toward resolution is disturbed or not attempted at all. In some cases, the bereavement becomes prolonged with intense grief symptoms that interfere with one's ability to function, whereas in others, it may appear as a complete absence of grief. The intense overwhelming grief symptoms of earlier stages become abnormal due to their persistence and duration. Even though others will recognize the prolonged and self-consuming nature of a person's grief, often the bereaved remains oblivious and unable to recognize the complicated nature of his or her grief. However, those few who are aware of their problem feel powerless to address it. There are many similarities in symptoms between complicated grief and some psychological disorders, such as major depression, anxiety disorders, and post-traumatic stress disorder. Usually the unresolved issues of a relationship are the predisposing factors for complicating the grief process for the bereaved. It is estimated that approximately 10% to 20% of the bereaved experience this kind of grief with the following symptoms:

- Chronic insomnia or other sleep disturbances
- Excessive and continuous preoccupation with the deceased and loss
- Experiencing physical symptoms similar to those of the deceased
- Death or illness fears or phobias
- Engaging in escape and reckless behaviors such as drinking, drug abuse, or promiscuity

- Inability to get back to the prior level of functioning at work, school, or in relationships
- Inability to talk about the person who has died
- Showing signs of depression, low self-esteem, or suicidal thoughts
- Exaggerated grief reaction to minor events related to the deceased
- Reluctance to change the room or move the belongings of the deceased

Clinical and scientific knowledge on this subject has identified several types of complicated grief, as presented in the next section.

Chronic Grief

When the bereaved continue to exhibit normal grief reactions for an extended period of time without coming to a satisfactory resolution, the grief becomes chronic. It appears to be an attempt on the part of the bereaved to keep the deceased alive by continuing the intense grieving process. The bereaved fail to complete the tasks involved in the process of mourning and fail to adjust to their environment without the presence of the deceased. The intense grief reactions that would be appropriate in the earlier stages of bereavement linger. These excessive and disabling grief reactions keep the bereaved individuals from returning to normal life. Their intense preoccupation with the deceased may manifest in frequent visits to the grave, their conversations centering around the deceased, continual sorting and arranging the possessions of the deceased, and keeping the room and possessions of the deceased as if the deceased were coming back. An ambivalent or dependent relationship with the deceased is usually the source of chronic grief. Those who experience chronic grief and cannot come to a satisfactory resolution are at greater risk of physical and mental illnesses. There is also a high risk of suicidal behavior.

Absent or Delayed Grief

Unlike the normal grief pattern, some people who lose a loved one may show absence or delay of normal grief symptoms. The delay in symptoms may last for months or years. They behave as if the death of the loved one did not occur or they could handle the loss without being emotional about it. However, a price is exacted for this denial and repression. At some later date, a full grief reaction may be elicited by a somewhat minor loss or even someone else's loss. Or the bereaved may experience a flood of emotions at the least expected times for which they have no understanding or explanation. Often the absent or delayed grief results from either a traumatic nature of the death or the inability of the person to take time to grieve the loss, either because of obligations at the time of death or the person's perceived inability to deal with the loss at the time the death occurred.

Inhibited or Distorted Grief

When grief is inhibited, individuals might be able to experience loss of some aspects related to the deceased but engage in denial of others. Few signs of grief may be demonstrated at the time of death, but later psychosomatic symptoms may develop or moodiness may set in as the bereaved becomes irritable and/or short-tempered. Some bereaved persons may distort the experience of grief by exaggerating one or more normal grief reactions, such as anger or guilt. They may also appear to be consumed by one or more extreme emotions. Complaints of headaches, heart palpitations, anxiety, and depression are common symptoms, as are displaced anger and hostility. These complications are experienced more intensely and frequently than normal grief reactions are experienced.

Unanticipated Grief

Sudden or traumatic deaths lead to unanticipated grief. Because of the sudden nature of loss, often the bereaved are unable to fully experience the normal grief reactions. Instead they may suffer from extreme feelings of bewilderment, anxiety, self-reproach, and depression, thereby making the recovery complicated. Because of the unexpectedness of death, there may be many regrets and lose ends identified. The bereaved may feel responsible for not preventing the death or may have a significant amount of unfinished business with the deceased, leading in turn to increased anger directed toward others. The prolonged grief experienced is further intensified by their need to understand why the person died and the search for the meaning in death. The unpreparedness often leaves the bereaved feeling vulnerable and out of control.

Their symptoms are similar to those identified as accompanying post-traumatic stress disorder and often require immediate intervention. If intervention is delayed, the symptoms might become chronic and more difficult to treat.

Masked Grief

Sometimes bereaved individuals might experience somatic or psychological symptoms or a maladaptive behavior, which at first does not appear to be related to the loss. Unable to recognize the relationship between the symptoms experienced and their repressed feelings about the loss, the bereaved may develop symptoms similar to those of the deceased, while at other times experiencing unexplained depression or paranoia. Repressed grief may also be acted upon through a maladaptive or delinquent behavior, such as promiscuity, drinking, gambling, and other self-deprecating behaviors.

Sangeeta Singg

See also Bereavement, Grief, and Mourning; Grief, Bereavement, and Mourning in Cross-Cultural Perspective; *Loved One, The*

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Grief and Bereavement Counseling

The unique pain of grief has been recognized and described poignantly in some of the most ancient texts and oral traditions of world cultures, but it is only in the past 50 years that formal organizations and professions have evolved to address the specific social, psychological, and spiritual needs of those persons who have lost loved ones. As the field of grief counseling has grown, it has also diversified, drawing inspiration from evolving theories of grieving while continuing to respond to the needs of various groups touched by often tragic loss. As it has done so, it has also begun to attract the attention of social scientists who have evaluated and sometimes criticized the field, raising questions about its basic assumptions, its social role, and its clinical efficacy. Although present evidence does not support the conclusion that formal bereavement services are of benefit to everybody, it seems clear that they are of considerable help to many, and especially those who stand in greatest need of assistance.

Models of Bereavement Intervention

Some observers distinguish between bereavement support, counseling, and therapy on the basis of

who delivers the services and who receives them. Bereavement support most commonly describes informal mutual support groups for bereaved persons in the community, such as those offered by many churches or synagogues, as well as those affiliated with national or international organizations, such as AARP (formerly known as American Association of Retired Persons) Widowed Persons Services, Mothers Against Drunk Driving (MADD), or The Compassionate Friends groups for parents who have lost children. But this category can also include services coordinated by health or mental health professionals, such as hospice bereavement care or national networks of services like those provided by Cruse throughout the United Kingdom. In these models, support is commonly offered to all bereaved people, or all bereaved by a certain kind of loss (such as those who have lost children or who have lost a loved one to murder, suicide, or an impaired driver), irrespective of their level of demonstrated distress or psychological disorder. Support may take many forms, ranging from simple provision of psychoeducational material or lectures on grief and trauma, through annual rituals of remembrance, to home visits and support groups led by a veteran member of the group, typically without professional training. Such support services have the advantage of minimizing the stigma of bereavement and mobilizing community resources, especially in the form of the presence, understanding, and practical counsel of others who have "been there" (through having suffered a similar loss) and who are coping with their circumstance.

In contrast, grief counseling usually denotes services provided or facilitated by a trained professional, such as a nurse, social worker, counselor, or psychologist. Counseling is more often provided to individuals or families, though group counseling led by professionals is also common. Grief therapy shares these features but is usually distinguished by its assumption that the client or patient is struggling with a problematic reaction to the loss, such as a diagnosable case of depression or prolonged grief disorder. For this reason, programs that focus on prevention of future mental health problems, such as those for children who have lost a parent or sibling, might more appropriately be termed grief *counseling* rather than grief *therapy*, per se. Both forms of services are provided in a range of settings such as hospitals, clinics, and counseling centers, though they also are offered by therapists of several disciplines as part of their independent practice. Gradually there has been a move, especially in the United States, toward considering grief therapy a specialized form of practice beyond general counseling and therapy, supported by certification programs such as those organized by the Association for Death Education and Counseling. In practice, however, distinctions among most forms of bereavement interventions are inexact and overlapping, in part because many settings offer services in multiple formats (such as individual or group) by multiple volunteer or professional support personnel. Generally speaking, professionally conducted grief therapy is appropriate when community support services are inadequate to deal with bereaved people who are struggling intensely for prolonged periods because of personal vulnerabilities, such as a disposition to major depression or acute concerns about abandonment by another. It also can be indicated when the losses with which people must deal overwhelm both the bereaved and those who attempt to support them, such as the premature death of a young person or the murder of a loved one.

Theories of Grief Counseling and Therapy

Judging from published literature on bereavement counseling, it is probably safe to say that most programs and services place emphasis on certain common factors, animated by the common assumption that it is good, in Shakespeare's phrase, to "give sorrow words" in contexts that permit the expression of feelings related to the death of the loved one and its aftermath. In keeping with the historical primacy of a psychodynamic perspective with its focus on "working through" bonds with the deceased in the service of "letting go" and "moving on," such therapy provides opportunities to review the relationship with the deceased and find symbolic ways to "say good-bye" with the respectful witnessing of a caring professional or other bereaved people. However, grief can be shared and explored in media other than words, as through expressive arts therapies that use drawing, painting, collage, mask work, sandtrays, music, and more, to give symbolic form to emotions and meanings associated with the loss and, especially in group-based programs, to seek validation for them. In

cognitive-behavioral models of therapy, both individual and group services also have incorporated an emphasis on education regarding basic grief and trauma reactions as well as practical coping skills, such as guidelines for seeking social support from others.

With the advent of contemporary grief theories, bereavement interventions have begun to diversify to feature processes of adaptive mourning emphasized by the various approaches. For example, some group programs have been organized around the presumed stages of grieving, with a series of weekly discussions of such topics as denial, anger, bargaining, depression, and acceptance. Other therapists facilitate theoretically important tasks faced by the bereaved, such as acknowledging the reality of the loss, confronting the pain of grief, and attempting to adjust to a world in which the deceased is missing. Alternatively, some research-based programs have drawn inspiration from meaning reconstruction models of bereavement, using narrative procedures to promote retelling of traumatic losses in order to better integrate them into one's life story. Other therapists help clients oscillate between the dual processes of loss-oriented coping (e.g., managing the intrusions of grief, seeking to relocate the relationship to the deceased) and restoration-oriented coping (e.g., pursuing new activities and investments, taking on new roles). Finally, a number of therapists promote systematic exposure to strongly emotional cues of the loss, whether through concrete behaviors such as visiting the cemetery or sorting through the loved one's belongings, or engaging in symbolic imaginary conversations with the deceased in an empty chair, in order to seek understanding, forgiveness, and a sense of continuing connection. The outcomes of studies on the effectiveness of such procedures are summarized in the next section.

Research on Bereavement Interventions

Volunteer support services have developed chiefly as a humane response to the pain of the bereaved, and professional grief counseling has been given impetus by cultural trends that view some form of therapy as a legitimate response to a wide range of human suffering. Recently, these same interventions have attracted the attention of social scientists who have attempted to understand processes of adaptation after profound loss or trauma and how these can be facilitated by various programs and procedures.

Studying bereaved people over time—even those who have the intended benefit of therapy—has made it clearer how difficult and extended the process of adapting to loss can be for many. For example, children receiving family services after the death of a parent are at risk of protracted disruptions of mood and behavior, especially when the surviving parent has trouble maintaining open communication and effective structure and discipline. Conversely, parents who have lost children to violent death from suicide, homicide, or accidents typically struggle with traumatic symptoms and grief for years or even decades, and fathers in particular display little benefit from even systematic therapies offering opportunities for sharing and discussion of coping strategies. Such results suggest that grief therapy is not a panacea for the pain of loss and that some people and families do not benefit greatly from the therapies that have been offered.

Studies comparing the progress of bereaved people who are randomly assigned to either treatment or no-treatment control groups underscore this conclusion. Although most people who participate in grief counseling or therapy report high satisfaction with services and also improve over time, it cannot be assumed that such improvement reflects the effectiveness of therapy, as they might well have experienced a lessening of distress as a function of natural processes of healing, their own efforts, or the social support available in their families or communities. Currently, it remains a matter of controversy whether grief therapy can at times actually aggravate people's distress, perhaps by fostering rumination on their loss or, in the case of group interventions, overwhelming them with the negative emotions of others. However, most reviewers of the scientific literature would agree that the evidence for the general effectiveness of grief therapy relative to no treatment is surprisingly weak. In many studies of interventions that are offered to all bereaved people, regardless of whether or not they show serious signs of depression, anxiety, or disabling grief, those who receive treatment do no better than those who do not. Although resolving the question of why this is so requires more research, it seems probable that this largely reflects the resilience of the majority of bereaved persons, whose grief is broadly in a

normal range and who ultimately will adapt well whether or not they receive formal intervention.

In contrast, those studies that screen the bereaved for distress, that offer services only to clinically referred or self-referred clients, or that concentrate on complicated, prolonged, or disordered forms of grieving are far more consistent in supporting the usefulness of grief therapy. For example, one important study compared a 16-week therapy called complicated grief treatment (CGT) against a more general interpersonal psychotherapy (IPT) with a large group of bereaved people who met criteria for disabling grief. Guided by the dual process model of bereavement, therapists in the CGT condition promoted the dual goals of helping clients both process their loss and seek restoration in a changed world that required the development of new life goals. Key interventions included not only psychoeducation about oscillating attention to these two processes, but also manual-guided therapeutic procedures delivered in three phases. The first of these was termed *revisiting*, in which the client was encouraged to tell and retell the story of the loss with eyes closed, as the therapist prompted her or him to deeper emotional engagement with the narrative. Clients were then instructed to listen to an audio recording of the retelling between sessions to overcome tendencies to cope with the loss through avoidance. In the next phase of *reconnecting*, clients were encouraged to review primarily positive but also negative memories of the loved one, as the therapist cultivated a significant continuing bond. This work was continued in imaginal conversations, in which a renewed connection to the deceased was fostered through two-chair dialogue with the lost loved one with the support of the therapist. Finally, in the *restoration* phase, clients were encouraged to envision viable life goals for themselves if their grief were not so intense, and then begin to work toward these. IPT followed its usual procedures by linking symptoms of grief to interpersonal problems and working toward a realistic view of the deceased and the development of satisfying relationships. Clients in both conditions showed improvement over time. Significantly, however, CGT was shown to be superior to IPT in reducing symptoms of complicated grief and improving participants' work and social adjustment, although the two treatments yielded comparable outcomes on measures of depression and anxiety. Other studies also reinforce the conclusion that specific treatments for complicated or prolonged grief can be effective over a few months when they help clients think realistically and hopefully about their situation, develop perspective on their loss, and orient to a changed future. Interestingly, these therapies tend to share a focus on telling and exploring the story of the loss in detail, whether in oral or written form, offering support for exposure to its most unsettling features, and providing opportunities for reconstructing a life plan in the wake of bereavement. As research on their outcome continues to accumulate, there is reason to believe that bereavement interventions can play a valuable role in mobilizing support for survivors, especially in circumstances of traumatic loss, and can mitigate the impact of prolonged and complicated grief reactions.

Robert A. Neimeyer

See also Bereavement, Grief, and Mourning; Homicide; Prolonged Grief Disorder; Sudden Death; Suicide, Counseling and Prevention; Suicide Survivors

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Grief and Dementia

Grief is a part of everyday life, especially for those affected by chronic dementia. Grief can be defined as the personal experience of a loss. By this definition every time a person forgets a favorite pen or discovers that she or he is no longer able to accomplish a task of any sort, human beings grieve a loss. For the average person, losses are categorized on a continuum from very minor to major. This rational process takes place every day when a pen is missing and the person simply grabs another. However, a loss like the death of a loved one is a significant event. Persons with dementia exhibit a loss of memory, but what many observers do not understand is that they also lose their capacity for rational thought. Thus, when a person has dementia this continuum of rational responses to the various types of grief situations becomes unclear both to the person and to those who care for that person.

Everyone who knows and cares about the patient who is confronted with a terminal diagnosis like Alzheimer's disease is impacted. The patient diagnosed with Alzheimer's disease in particular will experience a slow decline in mental and physical capacity that can continue for many years. Sometimes referred to as "the long good-bye," Alzheimer's disease, the most common form of chronic dementia, is the source of tremendous grief and sorrow, but it is not necessarily a shared grief between the patient and his or her loved ones. Traditional wisdom in the field suggests that family members primarily experience anticipatory grief, but it is not clear as to how, or even whether, the patient is able to grieve a significant loss. Recent research, however, suggests that a more complicated picture exists and needs to be included in the understanding of those in clinical practice.

Grief and Families

References to the experience of grief as it relates to the persons and families impacted by dementia begin in the early 1980s. However, research into grief reactions of families did not begin until 15 years later, and research into grief responses of persons who have dementia has only just begun. Early references to the family experience of grief as related to a person with dementia promoted the assumption that dementia, like other chronic illnesses, would invoke anticipatory grief (i.e., grief that occurs prior to a loss). The logic of understanding the grief of a family in this way stems from the theory that dementia is a chronic illness, much like cancer or a stroke. More recently, however, Alzheimer's disease has been defined as a terminal illness; this definition challenges the validity of employing the classical perspective of anticipatory grief for family members.

Anticipatory grief parallels conventional grief in that both reflect the emotional reactions of a person to a loss. Whether the classic stages of grief as articulated by Elisabeth Kübler-Ross in her 1969 publication *On Death and Dying* or the more recent tasks of mourning that J. W. Worden has employed, in both instances an event is generally the starting place for the grief reaction. When dementia is involved, the starting point to begin the process of grief is less clear. Paradoxically, the end point is also different. While in classical grief, the grief process can go on indefinitely, for the family with a senior who has dementia, the end point of anticipatory grief will be the death of the loved one. At this point the family is faced with the question as to whether or not the death signals the start of a second grief process in a more classical format. In short the struggle for families is to determine when their loved one actually dies. Is the person gone when they no longer recognize anyone in the family or is it when the body dies?

Possibly the greatest challenge for anticipatory grief is in knowing *when* to grieve *what* loss. In theory, when the person with dementia either can no longer perform a particular function or can no longer remember some significant bit of information such as the names of family members, these would be points of loss and thus sources of grief. However, many persons with dementia have good days and bad days. Loss of memory or ability may be gradual over time. The more invested the family is in caregiving, the harder it may be for them to accurately identify when a particular behavior started or memory was lost. Frequently, the burden is on out-of-town relatives or other persons who see the senior with dementia only periodically to more accurately identify losses since their last visit.

A Stage Sensitive Caregiver Model

A recent development is a stage sensitive caregiver model, a model that is based on research that identifies distinct differences between the ways family members grieve. Isolating three stages each family member goes through, these parallel the stages involved in the advancement of the dementia process. The most striking distinctions reflect the distinction between adult child and spouse caregivers. In the first stage of grief, adult child caregivers are more likely to be experiencing denial and avoidance, refusing to acknowledge any future implications of the disease. Spouses, on the other hand, are much more reality oriented and ready to face the future. The role of denial or relative lack of denial is made up when movement takes place to the second stage. For the adult child in the second stage, there is a rapid transition to the reality of care and the experience that the burden is much greater than expected. For the spouse, it may be hard to identify the second stage, as the transition is smooth and accepting the increased burden is seen simply as part of the job of caregiving. The third stage is marked by nursing home placement or significantly greater external resources employed. For adult children this reflects a shift of caregiver burden to the nursing home or agency staff. For the spouse, the care of the impaired senior is reduced, but generally the need of considerable self-care begins. Like any other stage theory, the challenge of this sequence is to accurately identify when the caregiver is in transition between the three stages. However, this system offers an important alternative to that of anticipatory grief for persons working with families caring for a loved one who has dementia.

Grief and the Person With Dementia

Understanding the grief process of persons who have dementia can be even more challenging. It is important to note that persons with Alzheimer's or other related disorders do attempt to cope with the changes that affect their lives. This type of observation has been made by numerous researchers; however, until recently, little has been done to understand how grief affects the person with dementia. Communicating this type of experience for the person with Alzheimer's disease is limited by the patient's inability to articulate coherent feelings and then remember them for further dialogue. Based on the inconsistent cognitive capacity to process events such as the death of loved ones, it is understood that persons with dementia will vary in their response based on diagnosis and stage of the disease and even time of day.

In one recent study it was reported that persons who have dementia do experience grief at the time of a significant loss. However, it is often not expressed in ways that are consistent with normal grief responses. Three types of responses are identifiable. First, when family members inform the person with dementia about the death of a significant person like a spousal caregiver, the senior responds, not by articulating remorse for the loss, but by expressing concern for his or her own needs with a response like, "Well, who will take care of me now?" This type of self-care should be a part of every family member's response at some point, but usually the loss for self comes after the experience of the loss of the loved one. This type of subject-to-object reversal can be confusing, particularly for adult children who continue to perceive their mother or father as a role model for coping with their own grief process.

The second response is that of a person who seems to understand that someone has been lost, but simply cannot remember who. This person then becomes fixed on the death of a loved one such as a child or a parent who died many years earlier before the onset of dementia. In such cases, the person displays a genuine grief response specific to a person lost at a different time often putting them through, for a second time, a very painful experience that was processed many years ago.

The third response involves the transfer of the loss to an inanimate object. For example, the impaired senior may suddenly lose a pen, possibly one that family or other caregivers don't even know about, at about the same time as she or he is told of the death of a loved one. The senior is generally adamant that the pen is lost or stolen, yet no one is able to find the pen. The coincidental loss of the pen and the death of the loved one suggest that the senior understands that a loss has taken place, but simply has the wrong loss, fixating on the object, rather than the loved one.

Each of these three forms of grief should be understood as existing in a range of behaviors; however, the patterns are consistent. It is striking to now examine the reactions of the senior to that

of their family. When families realize some relief from caregiving for the person with dementia, the patient may confound the family in terms of their need to grieve. Preliminary evidence suggests that this can then lead to the rejection of a valid grief experience by the family.

Similarly, hospital staff, when confronted with what appears to be an inconsistent grief response, assume that it has no connection to the grief event. Thus any behaviors on the part of the senior with dementia that are out of the ordinary are viewed as problem behaviors and are often medicated rather than treated as a part of an authentic grief experience, different from that of the family or other expectations of normal grief.

In sum, the people with dementia, as well as their families, are confronted by numerous factors that can change even the expected patterns of response. Families, spouses, and seniors who have dementia all grieve with their own unique patterns and issues. Researchers and caregivers need to approach all three from the perspective of the stage of the dementia with the understanding that no one is immune from the feeling of grief. The difference is in how the individual manages and expresses grief.

James W. Ellor, Howard Gruetzner, and Nicole Back

See also Grief, Types of; Grief, Bereavement, and Mourning in Cross-Cultural Perspective

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Halloween

Halloween, celebrated on October 31, originally marked the beginning of the dark half of the year. Once tied to seasonal shifts and pastoral cycles in northwestern Europe, Halloween has always been seen as a portal for the spirit world. The imagery of Halloween is often the imagery of death—skeletons, corpses, ghosts—and Halloween's association with death and the spirit world can be seen in its Celtic mythological origins, its incarnation as a medieval church holiday, and its rendering in modern popular culture.

November 1 was once called *Samhain,* or summer's end, and marked the beginning of winter in the British Isles and Scandinavia. Samhain was first noted in Irish mythological sagas recorded by medieval monks as a time when demons were released, great kings slain, and sacrifices made. Fairy mounds opened to reveal the otherworld, and it was on Samhain that a magical fog lifted to reveal the dead. In 17th- and 18th-century Ireland, men returned from work abroad to spend the winter with their families on Samhain. The dead were so much a part of the Irish family that they would have been included in any reunion. People left out food and drink for them or kept an empty chair near the fire.

A series of medieval papal edicts instituted a church feast day to honor all saints that was eventually set on November 1 by Pope Gregory IV in 835. All Saints was known as All Hallows in Britain (*Hallow* meaning holy or one who is holy) and the evening before, as All Hallow's Eve, or Hallowe'en. Although Halloween owes its name to All Saints, it owes its association with death and the spirit world to the November 2 feast of All Souls.

Conceived around 1000 C.E. in the French monastery of Cluny and then set on November 2 by Peter Damian in 1063, the feast of All Souls was a time to pray for friends and family who had died. At the end of the 12th century, church liturgists emphasized the pairing of All Saints and All Souls feasts, sometimes called Hallowtide, to underscore how the living could hasten the journey of souls through purgatory. Saints, they taught, could intercede on behalf of the dead, and prayers or contributions could shorten a loved one's stay in purgatory. People came to believe that if this was true, then souls in purgatory could also return to haunt the living.

All Hallows was considered both a religious and an otherworldly time. Church bells rang throughout Western Europe to remember the dead. Italians in Naples opened charnel houses and dressed cadavers in robes for display. Halloween "guisers" (people dressed in monstrous costumes to resemble the dead) made a ruckus at court in 16th-century England, and in the countryside, bonfires blazed to ward off spirits. Some also carved turnips—representing souls trapped in purgatory—and went "souling" door-to-door or begged for small breads called "soul cakes" in return for prayers. The custom was common enough in Shakespeare's day that his character Speed (*Two Gentlemen of Verona,* first performed 1594–1595)

derides his love-struck master for "puling [whining] like a beggar at Hallowmas."

The Protestant Reformation condemned the idea of purgatory, as well as church holidays, as pagan or papist. Reform diabolicized ghosts and the Enlightenment of the 18th century gradually nudged supernatural beliefs into the realm of folklore and superstition.

Beginning as early as the 16th century, the first folklorists, called antiquarians, collected superstitions, ballads, and stories of the "peasantry" of the British Isles and beyond, fearful that old customs would be lost in the onslaught of a new industrial society. Halloween folklore, researched avidly in Britain, was used to enliven Victorian periodicals and almanacs, and to lend atmosphere or a rustic mysticism to the extremely popular literature of writers such as Robert Burns (1759–1796) and Sir Walter Scott (1771–1832) in Scotland, and William Butler Yeats (1865–1939) in Ireland. Generations of readers throughout Europe, Canada, and America came to know Halloween as a time when fairies could snatch babies, when the night sky grew thick with witches, or when a dead lover could return for a few sweet hours. By the turn of the 19th century, Halloween was widely acknowledged as the night one could glimpse the spirit of a future mate through fortune-telling tricks using apples, nuts, water, and fire.

In the late 19th century, anthropologist Sir James George Frazer proposed his theory that folkways were vestiges of pagan practices, and that Halloween originated in a festival of the dead. Frazer argued that the church placed its All Saints and All Souls feasts on November 1 and 2 to supplant pagan rites. Contemporary historian Ronald Hutton suggests it's just as likely that what Frazer and others recorded as the remnants of ancient beliefs were really half-remembered Catholic teachings.

Contemporary Halloween costumes still conjure the dead (skeletons, bleeding zombies, serial killers), as does Halloween imagery (tombstones, corpses, bones), but this modern association with death is now more rooted in popular culture than folklore. Films such as the seminal 1978 John Carpenter film *Halloween* recast the holiday as darkly evil, and a new popular literature emerged in which Halloween's relationship with the dead was mined for horror. In the late 20th century, stories of death by poisoning and razor blades in Halloween treats made headlines, although further research proved them to be hoaxes or urban legends.

Modern-day pagans, who practice an earth-based spirituality, mark Halloween as a time to honor the memory of the dead. For all other celebrants, the otherworldly elements of Halloween have moved into the realm of fantasy, satire, and entertainment, making Halloween one of the 21st century's most creative holidays.

Lesley Bannatyne

See also Day of the Dead; Ghosts; Holidays of the Dead; Serial Murder; Zombies, Revenants, Vampires, and Reanimated Corpses

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Halo Nurses Program

The Halo Nurses Program involves retired registered nurses (RNs) who give supportive care to hospitalized patients and families in the midst of crisis situations that may include terminal illness and end-of-life concerns. Halo Nurses serve at Akron General Medical Center (AGMC) in Akron, Ohio, and are supported by the Akron General Development Foundation.

History

Eileen Machan, RN, began the Halo Nurses Program at Cuyahoga Falls General Hospital soon after her retirement in 1996. She had observed the increasing work pressures and constraints on nursing staff in acute care settings and recognized that the supportive, listening, comforting aspects of care often had to be minimized due to time constraints. Ms. Machan and several other nurses visited patients and families who were referred by

nurses or physicians with a focus on therapeutic listening. Patients and staff found the work of the Halo Nurses to be effective. Additionally, the nurses themselves were able to use their extensive nursing experience to provide support and encouragement to patients and families and had the satisfaction of helping others.

Though the Halo Nurses were essentially volunteers, they were given a small stipend to compensate for travel, continuing education, and liability insurance. This was provided through the Halo Foundation, Inc., a nonprofit group. The hospital did not pay the nurses for their visits.

In 2001, Jon Trainor, President of Akron General Development Foundation, asked Ms. Machan to move the program to AGMC. Halo Nurses initiated the work on two medical/surgical units and one oncology unit. Since then they have been available on other units throughout the hospital. They continue to receive a stipend to cover expenses but no salary.

Mission and Purpose

Halo Nurses focus on assisting patients and families dealing with a variety of health care crises. According to the *Halo Nurses for Supportive Care* brochure, the goal is to offer care "that complements traditional medical care by providing patients the physical and psychological tools to deal more effectively with stress and pain of serious illness." The nurses have strong clinical care backgrounds that give them skill in assessing situations and how they may help. In addition, they are specially trained in using therapeutic listening, relaxation techniques, guided imagery, and healing touch. They do not give direct nursing care, such as medications or other therapies, but may reposition a pillow, give a back rub, or give other comfort care as approved by the staff. The nurses are to supplement the medical and nursing care that is being given, not replace it.

Referrals for Services

Nurses, physicians, and other members of the health care team refer patients and families. Halo Nurses have an office at the hospital with voice mail so that referrals may be received. A Halo Nurse then responds and makes an initial visit. The recipients of care are those who are dealing with stressful situations and who may benefit from the listening ears and comfort measures offered by the Halo Nurses.

Qualifications of Halo Nurses

Halo Nurses are retired or are not currently in active nursing practice. They are required to have a current RN license to practice in the state of Ohio and current nursing liability insurance. They must have a strong clinical background, strong spiritual grounding, and experience in holistic nursing modalities such as relaxation techniques. They have to verify that they have read and agree with the Halo Nurses' Code of Ethics and Standards of Practice. Additionally, they commit to attending at least one seminar yearly pertaining to holistic care. The Halo Nurse Coordinator holds monthly meetings with the nurses to assure continued excellence of the program and also determines the need for additional nurse consultants.

Provision of Services

The Halo Nurses are available Monday through Friday during daytime hours, though occasionally someone will come in the evening to better meet the needs of patients and families. Each day, two or three nurses work 4 to 6 hours at a time. The nurses usually work 1 to 3 days a week. When a referral is received, a Halo Nurse goes to the hospital unit, reviews the patient's chart, and spends an average of 45 minutes with the patient listening and determining supportive care that might be offered. The nurse then charts the visit on the appropriate forms so that the medical and nursing personnel are aware of the visit and the Halo Nurse's involvement in the supportive care of the patient. Halo Nurses usually devote their time to patients with high anxiety or hard to manage pain. The patients may be facing a serious diagnosis or may be in a deteriorating or terminal state due to cancer or other serious illness. The Halo Nurses also make regular rounds on medical/surgical, oncology, and perinatal units where the charge nurse may ask them to visit a patient in need of a "listening ear." The patient is frequently the focus of the work of the Halo Nurses, but a family member may also be referred to receive

emotional support and help in dealing with the stresses of being a caregiver.

Benefits of the Program

The Halo Nurses Program is a model for providing needed therapeutic interventions that may go missing for patients and families in a busy hospital environment. At AGMC, the staff, patients, and families consistently give positive feedback for the program. The hospital has received high patient satisfaction scores in recent years, and leaders give some credit for that to the Halo Nurses Program. The Halo Nurses themselves also benefit by being able to continue using their considerable nursing backgrounds and interpersonal skills to serve patients and families facing health care crises.

Linda W. Olivet

See also Caregiving; Death, Clinical Perspectives; Terminal Care

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Hate Crimes and Death Threats

Hate crimes, also known as bias crimes, are crimes against people, property, or society that are motivated, in part, by a bias against real or perceived characteristics of the victims. Hate crimes include a wide array of criminal offenses, such as murder, death threats, church burning, theft, and vandalism. Statutory definitions of hate crimes vary in the number and victim characteristics specified, but generally include race, religion, and ethnicity/national origin. Sometimes disability, sexual orientation, gender, transgender/gender identity, political affiliation, and age are included as protected classes, although whether to include some of these has been controversial at times. In some cases, hate crime legislation requires data collection, training for law enforcement personnel, and provisions for sentence enhancement for offenders. Hate crime legislation also allows for civil action. The criminal category of hate crimes has both supporters and opponents.

Although the legal category of hate crimes is relatively new, violence, death threats, and other crimes motivated by hatred of particular characteristics of the victims are not a recent phenomenon, nor are these actions limited to the United States. Jews, Tutsis in Rwanda, Protestants and Catholics in Northern Ireland, immigrants and refugees in Sweden and Italy, civilian members of the Fur, Zaghawa, and Massaleit ethnic groups in Darfur, Aboriginal people in Australia, and Mormons are examples of groups that have been targets of violence because of their ethnicity, race, or religion.

Hate Crime Laws

Lynching, cross burning, death threats, intimidation, and other forms of violence against African Americans, most notably by the Ku Klux Klan, were so common after the Civil War that the federal government responded, in part, by passing the Civil Rights Act in 1871. Approximately 100 years later, the first federal law to specifically mention characteristics of the victims was passed because of the bias-motivated crimes that garnered national attention during the civil rights movement. This law granted federal authority to investigate and prosecute those who use force or threats of force to willfully injure, intimidate, or interfere with someone because of the victim's race, color, religion, or national origin when he or she was attempting to engage in federally protected activities, such as attending school, being employed, traveling, and securing lodging.

In the 1980s, groups that advocated hate against marginalized groups, particularly African Americans, gays, lesbians, and Jews, became more visible. The use of the term "hate crimes" became associated with some actions of organized hate groups, such as the Confederate Hammerskins (racist skinheads),

League of the South (neo-Confederates), Americans for Self Determination (white nationalists), Victory Nights of the Ku Klux Klan, and White Revolution (neo-Nazis). Hate groups continue to proliferate. In 2007, the Southern Poverty Law Center identified 888 active organized hate groups, which is 48% more than in 2000.

In 1990, Congress passed the Hate Crime Statistics Act (HCSA) requiring the Attorney General to gather and make available to the public data about crimes motivated by prejudice based on race, religion, sexual orientation, or ethnicity. In 1992, the Uniform Crime Reports included data on hate crimes for the first time. Two years later, Congress passed the Violent Crime Control and Law Enforcement Act that expanded the requirements of the HCSA to include hate crimes against people with disabilities.

According to the Anti-Defamation League, all states and the District of Columbia (DC) have criminal penalties for bias-motivated violence and intimidation, except Arkansas, Georgia, Indiana, South Carolina, and Wyoming. Combining state and DC laws, 45 include race, religion, and ethnicity, 31 include sexual orientation, 31 include disability, 27 include gender, 22 include religious worship, 13 include age, 10 include transgender/gender identity, and 5 include political affiliation.

National data on hate crimes are primarily generated by the Uniform Crime Reporting (UCR) Program and the National Criminal Victimization Survey (NCVS). These two sources paint a considerably different picture of the frequency of hate crimes, with the NCVS data indicating that hate crimes are considerably more common than captured in the UCR data. According to UCR data, in 2006 there were 7,722 hate crime incidents, 9,080 offenses, and 9,652 victims that included individuals, businesses, institutions, or the larger society. A bias crime against the victim's race/ethnicity was the most common motivation, followed by sexual orientation and religion. From 2000 to 2003, NCVS data indicated an annual average of 210,000 hate crime victimizations and 191,000 hate crime incidents. Of these totals, 84% were violent crimes.

Death Threats and Murders

In some states, when a death threat is made against a member of a specified group, the threat can be considered in determining whether a hate crime has been committed. As with hate crimes, what constitutes an illegal death threat is a complex legal issue, often linked to First Amendment rights. In general, a death threat is not protected speech if there is intent to follow through with the threat. Other factors are considered in determining an unlawful death threat, such as the context in which the threat occurred and whether the target is fearful of serious harm. The means by which an illegal death threat can be communicated include speech, telecommunications, mail, e-mail, and the Internet.

Since 1996, 118 murders were classified as hate crimes. UCR data indicate that the some murders were motivated because of a bias against the victim's race or ethnicity—white (19%), black (27%), Asian Pacific (5%), Hispanic (14%), and multi- or other race (7%)—and others because of the victim's religion (4%), sexual orientation (22%), or mental disability (1%).

Two savage murders illustrate the types of violence associated with some hate crimes that have helped garner public and political support for hate crime legislation and enhanced sentences. Three white men picked up James Byrd Jr., a black man, while he was hitchhiking in Jasper, Texas. Driven to a rural dirt road, he was severely beaten, and then chained by his ankles to the rear bumper of the vehicle. The men dragged Byrd for several miles. Police discovered Byrd's torso on the road and followed a trail of blood that led to Byrd's head and arm in a ditch, approximately one mile from where his torso was located. Byrd's attackers were white supremacists.

In another murder, two men, on the pretext of a sexual encounter, lured Matthew Shepard, a college student in Wyoming, from a bar. The men then robbed, pistol whipped, and tied Shepard to a fence, where he was left to die. Shepard remained there for approximately 18 hours in near-freezing temperatures before a passerby discovered him. Matthew Shepard died 5 days later because of the severe brain damage inflicted by the men who were offended by his homosexuality.

Sentencing Enhancement

One of the most controversial features of hate crime laws is sentencing enhancement. The Hate Crimes Sentencing Enhancement Act required the U.S.

Sentencing Commission to increase sentencing by at least three offense levels for offenders who were found guilty of a federal crime in which the victim was targeted because he or she belonged to a group specified in the federal hate crime laws. State laws relating to sentencing enhancement vary. For example, some laws require that an enhanced sentence be added to the sentence that would be given if the crime were not classified as a hate crime, while others only enhance the sentence for particular hate crimes, such as assault or property damage.

Support and Opposition to Hate Crime Legislation

One argument made by proponents of hate crime laws is that hate crimes lead to greater psychological and physical harm than other crimes, with the harm extending beyond the victim to the victim's family, other members of the target group, and society at large. Another reason given for support of hate crime laws, particularly with enhanced penalties, is that they deter potential offenders, although the evidence that supports this claim is weak. Frequently articulated arguments are that these laws have important symbolic value by articulating and reinforcing the principle that all citizens should be allowed equal participation in a democratic society and that hatred that is translated into action against members of protected groups will not be tolerated. For supporters, the issue is about justice and security for targeted groups and is not about special rights to some citizens over others. Some posit that hate crime laws prevent large-scale retribution by members of the victim's protected class that otherwise might occur if there were no legal recourse. Those who are in favor of hate crime laws stress that the laws are not designed to curb free speech granted in the First Amendment. Rather, they say that hate crime laws allow legal recourse for speech that is not already protected by the Constitution. Further, proponents note that considering the motivation is already done in criminal proceedings, so taking into account the motivation for hate crimes is not beyond the boundaries that are currently being practiced.

Those who are opposed to hate crime legislation frequently argue that these laws are not needed because the crimes included in hate crime statutes are already criminal offenses. In contrast to supporters of the laws, opponents posit that empirical evidence is lacking for the claims of increased harm and that most hate crimes are relatively minor in spite of the high profile cases. Opponents argue that the laws reflect identity politics and political influence of groups, such as women's rights and gay liberation movements, rather than addressing real problems. They assert that free speech is being increasingly violated as hate expressed through e-mail, the Internet, and other non-face-to-face communications are being considered illegal under hate crime laws. A major concern is that hate crime laws prioritize some victims over others, to which supporters respond that this is already being done, such as when killing a police officer is a capital crime in some states when other murders are not. Those who argue that hate crimes are not needed state that there is no evidence that hate crime laws will improve intergroup relationships. Opponents are also concerned about what they see as the proliferation of protected categories, such as the recent inclusion of transgender people by some states, and believe that the laws are too vague to be enforced. Another argument is that the enhanced sentences associated with some hate crimes only increase the already overburdened prison system.

Heidi F. Browne and Carol A. Bailey

See also Gender and Death; Homicide; Lynching and Vigilante Justice; Race and Death; Wrongful Death

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Heaven

Heaven is one the cardinal representations of life after death. Even outside conventional religious circles, the image of the dead sojourning in heaven is popular. Generally speaking, heaven is a metaphor for another world distinct from the here and now. It is a transcendent sphere beyond the immanent world, yet observable from the here and now. Among the connotations of heaven, the first to be discussed is a cosmological meaning of heaven. Second, there is the religious meaning of heaven; Heaven in the sense of a divine world and the place where the dead dwell. Connected to this, there is hell, being the antipode of heaven. Besides this religious meaning, heaven symbolizes the consummation of the world at the end of time. Finally, in modern thinking, we find a new, more immanent meaning assigned to heaven.

The Cosmological Meaning of Heaven

Heaven has a cosmological meaning. It is part of the cosmos in which human life is conducted. It is the uppermost part of the cosmos and, in addition to its natural meaning, may have a religious or spiritual connotation. People on earth have always raised their eyes heavenward and sought to understand what they saw. In the past, heaven was regarded as the upper limit of the world. At a certain point vision ends, and this limit was interpreted as heaven. An example is the ancient Eastern worldview. In this view, the world was perceived in three parts. At the bottom was the primeval flood, representing chaos; in the middle was earth, where people lived; and finally, heaven was located at the top, above the earth. In the observable space where life took place, according to this worldview, heaven constituted the visible, spatial boundary of earth.

Modern scientific development changed this perception of heaven. People could travel to heaven, discover stars and planets, and literally come to grasp that the cosmos is vaster than what is visible from earth. This new human ability to explore the cosmos altered the meaning of heaven as a limit. In fact, the focus was now on the boundlessness of the heavens. This shows how dependent people's image of heaven is on their cultural context and worldview.

Besides this spatial meaning of heaven as part of the cosmos, it can have a spiritual meaning as well. This often relates to the stars. By ascribing certain spiritual forces to the stars, heaven's cosmological reality influences life on earth. There is a link between heaven and earth. Here, the relation between astronomy and astrology is pertinent. Astronomy is the science that seeks to improve observation of the heavens and the study of stars. Astrology, on the other hand, is a system of meanings attributed to the stars and the heavens. In this perspective, life on earth is directed from the heavens. In these two areas, we find, on one hand, scientific insight into the stars, and on the other, mythological interpretive patterns such as constellations that can be used to understand individual human lives. In both perspectives the stars exercise a powerful fascination. The part of the cosmos that lies beyond the human life world signifies transcendence of the life world. It also permits people to interpret death: Cosmologically heaven symbolizes human life as part of a larger whole in both an observable and a mythological sense. This may be associated with the notion that death is not the final limit of human existence.

The Religious Meaning of Heaven

Heaven also has a religious meaning. In religions it often symbolizes the divine. Heaven is seen as the divine world transcending the here and now. It is the abode of God or the gods—sometimes of angels and other supernatural beings as well. This makes heaven a transcendent, divine form of

existence inaccessible to human beings. In the Abrahamic religions we find concrete representations of heaven, such as paradise. This was where people lived after creation and from which they were driven as a result of sin. Paradise is guarded by angels, who see to it that this abode of God is preserved for people whom God takes into heaven. Islam represents heaven as a luxuriant garden where rivers of wine, milk, honey, and water flow. This, too, has connotations of a paradise, where the limitations of earthly life do not apply. To human beings, this place is inaccessible.

Yet people have always tried to gain access to heaven and to establish contact with it even while living on earth, for instance by way of ecstatic practices. One example is shamanism. A shaman is someone who can make contact with another world beyond normal human perception. Through rituals a shaman is able to communicate with spirits belonging to the celestial realm. In the Abrahamic religions, mysticism is a way of knowing heaven even before reaching paradise. Mystics are able to form an idea of what divine reality in heaven represents.

Christianity adds a further dimension to the notion that people can share in heaven even while they are still on earth. After his death, resurrection, and ascension, Jesus Christ assumed the place at the right hand of God the Father. Because Jesus, a being both human and divine, occupies this focal position in heaven, heaven is conceivable and accessible to Christians. Their relationship with Christ becomes the way to heaven where God sits. It also has an ethical connotation: At the behest of heaven people ought to live righteously as Christ has commanded them. In Christian terms, solidarity and love of others makes it possible to experience heaven while still on earth.

Connected with the religious meaning of heaven, it has also meaning for the dead. As an extension of the religious meaning of heaven as the domain where God and the angels rule, heaven acquires the meaning of a place for the dead. In many cultures, heaven connotes a home for humans in a transcendent sense: They are descended from preexistent soul, and the souls of the dead can then become, for example, ancestors. That implies that people on earth are descended from heaven and will return there after death. According to ancient Egyptian belief in immortality, the deceased leaves the grave, goes to heaven, and dwells there among the gods. Thus, the lid of the coffin symbolizes heaven because heaven is reached via death. For concrete representations of the place that the dead occupy after death, the aforementioned images of paradise are vitally important. They also determine how heaven that awaits one after death influences one's earthly life. Here the ethical connotation of righteous conduct in this life is pertinent. Heaven is where those who led righteous lives end up.

The antipode of heaven is hell. This is where people end up if they did not live righteous lives. Like heaven, there are concrete representations of hell in many religious traditions, including Christianity. In Christianity, hell is the abode of fallen angels (Lucifer) and demons who turned away from God. People who go to hell after death endure great suffering, such as burning in eternal fire. Decisive for many portrayals of hell is the aforementioned cosmological image of heaven as somewhere above, and hell as the realm below. According to these representations, good souls go above and bad ones below. In the Middle Ages, the Christian tradition saw the addition of the image of purgatory as well. This is a kind of intermediate state for people who have to do penance for sins committed in their lifetime. Unlike the dead who end up in hell, they have a chance of reaching heaven after a period of punishment.

There are many literary portrayals of these three components of the hereafter: heaven, purgatory, and hell. A famous example is Dante Alighieri's epic, *La divina comedia* (The Divine Comedy). In this work, the poet describes his journey through the hereafter: *inferno* (hell), *purgatorio* (purgatory), and *paradiso* (paradise). Here the religious interpretation derives, as noted already, from a cosmic worldview. In Dante's Ptolemaic worldview, half of the earth is inhabited, the other half is sea. Hell is inside the globe and originated when God cast the angel Lucifer from heaven. Purgatory is a mountain in the middle of the sea. Heaven consists of nine circles or spheres girdling the earth. The dead can eventually reach these via the mountain of purification, which corresponds with purgatory. This imaginary world exemplifies the way people attempt to give a plastic portrayal to the form that life after death may assume. The Islamic version of heaven comprises seven layers. According to Islamic doctrine, those who reach

heaven after death are waited on by virgins and youths. This is another way of portraying the paradisial nature of heaven for the dead.

Eastern religions offer a different perspective. In these traditions, people do not believe in eternal life after death but in reincarnation or rebirth. In this view, heaven, hell, and purgatory do not exist. What is known is heaven is not an eternal sojourn, nor is it a final consummation at the end of time. In Buddhism there are various heavens in which people who have lived righteously and earned good karma are reincarnated as a kind of god (*deva*). In due course, however, this heavenly period comes to an end; the deva dies and is reincarnated once more until nirvana is reached as the final state.

Heaven as Consummation of the World

Heaven represents the consummation of the world. Apart from being the destiny of individual people, heaven also connotes the destiny of humankind collectively and the whole world. It is the fulfillment of humanity and the earth's relationship with God in the end time (Eschaton). In Judeo-Christian terms, this relationship starts for individuals during their earthly lifetime, and for the earth it started at the time of creation, but it is only fully realized by coming face-to-face with God in heaven on the day of the Final Judgment. People will fully experience what started on earth when the end-time dawns. Then the graves of the dead will open, and they will stand before God's throne of judgment. The good will go to heaven forever. The notion that this happens at the end of time is also featured in Islam. In Islam, the dead pass through a phase of sleep after death. They are only judged by God much later, at the end of time. Judaism, Christianity, and Islam all see heaven as a final state to be achieved one day.

The Immanent Meaning of Heaven

In modern thought, heaven has acquired a new, more immanent meaning. Often it is depicted as a further dimension of earthly reality rather than a concrete place. Ever since the Enlightenment, thinkers—including religious thinkers—have focused on the here and now rather than on some place beyond earthly reality. The worldview has changed to the extent that heaven is no longer conceived of as primarily in a spatial sense. Yet in this context, thoroughly new utopian images of heaven have emerged. In modern scientific thinking, heaven is interpreted as the essence of everything that humans can achieve by harnessing the limitless potential that nature and the cosmos offer.

Currently there appears to be fresh interest in heaven. For instance, it is evident in modern art, which seeks to express the transcendent. Also in people's experience of bereavement, heaven plays a major role. Research into obituary notices shows that people derive hope from the idea that they will see their loved ones again in heaven after death, and that their loved ones have a place in heaven, from where they watch over and help the living in their lives.

Thomas Quartier

See also Angels; Christian Beliefs and Traditions; Eschatology; Hell; Jewish Beliefs and Traditions; Muslim Beliefs and Traditions

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Hell

Hell, in its most pervasive theological sense, refers to the state of eternal suffering after death. Hell has also been conceived as a place in which such suffering is endured or inflicted. The contrasting concept, heaven, is usually taken to mean an endless postmortem state of supreme joy and blessedness. In both Christianity and Islam, the blessedness of heaven is associated with the direct experience of God, what Christians call the beatific vision. Hell, by contrast, involves alienation from God. The doctrine of hell is the belief that at least some

people, after death, endure hell. While this doctrine is primarily associated with Christianity, other religions have parallel or related doctrines.

Many religious scholars believe that Zoroastrian influences played a crucial role in the formation of Christian ideas of heaven and hell. In mature Zoroastrian theology, however, hell was not conceived as an eternal state, but as one that would persist until the end of history, when the final defeat of Angra Mainyu (the Zoroastrian devil) by Ahura Mazda (the Zoroastrian god) would also bring about the salvation of the damned. The Zoroastrian doctrine demonstrates that although hell is usually thought of as an eternal or everlasting state (and while this has certainly been the dominant view in the history of Christianity), it can be conceived as temporary.

The focus in this entry is on the Christian doctrine of hell. Within Christianity, this doctrine has two important rivals: the doctrines of universalism and annihilationism. Universalism holds that, ultimately, all people are saved. Interestingly, universalism is consistent with belief in a hell similar to the one endorsed in Zoroastrian theology—as a state of suffering that endures, perhaps for a long time, before culminating in salvation. Historically, Christian Universalists have tended to accept the existence of something like hell—that is, intense postmortem suffering among those who die rejecting God. But they conceive such suffering as serving a reformatory purpose, ultimately contributing to the salvation of the sufferer. In the theologies of such seminal Christian Universalists as Origen and Gregory of Nissa, the "fires" of hell are thus taken to be purging fires.

Views of Hell

Annihilationism more decisively rejects hell in favor of the view that those who die unregenerately are utterly destroyed, and thus experience neither suffering nor pleasure. Annihilationism shares with the doctrine of hell the idea that those who die unregenerately are subjected to eternal punishment, and that there is no possibility of salvation once the punishment is imposed. But it denies the claim that God would subject the unregenerate dead to eternal suffering.

Among these alternatives, the doctrine of hell has the status of orthodoxy. But this doctrine itself comes in different forms. The classical doctrine of hell holds that damnation results from an act of divine justice. That is, God imposes the sufferings of hell on the damned as a just punishment for sin. And the afflictions of hell involve not just loss of the beatific vision and all goods that go with it, but also positive bodily and psychological pains inflicted by God for punitive reasons.

On this view the damned, by sinning against God Himself, come to deserve the worst evils that it is possible to inflict. Following Saint Anselm, most defenders of the classical doctrine have argued that because God is infinitely good and deserving of unlimited praise and worship, those who sin against God commit a sin of infinite severity, and thus deserve a punishment that is likewise infinite. Eternal suffering of the worst sort is therefore demanded by justice. God, motivated by justice, metes out precisely what sinners deserve.

Some classical Christian thinkers have even sought to enumerate in detail the kinds of sufferings that God imposes on the damned, distinguishing between afflictions of body and those of the soul, and between afflictions that are simply the result of being deprived of the vision of God and those that are imposed by God as a further punishment for sin. A few classical theologians have made the interesting point that, based on Christian value oriented assumptions, the worst affliction that anyone can suffer is not bodily or psychological pain, but sin itself. And so, if the damned deserve to have the worst possible afflictions imposed on them, God would need to ensure that they remain forever wicked, because being wicked is in itself a far worse fate than any further affliction that accompanies it.

According to this classical view, God is the immediate cause of damnation and its attendant sufferings. Furthermore, hell is not treated as a regrettable evil, but as a positive good. Some classical Christian thinkers, most notably Saint Thomas Aquinas, stated explicitly that the damnation of the wicked is a fact to be celebrated. According to Aquinas, witnessing the sufferings of the damned would actually magnify the delight of the blessed in heaven, who would rejoice in the just punishment of unrepentant sinners.

Many issues are related to this classical doctrine of hell. Some analysts have argued the doctrine of hell comes into conflict with other doctrines

pertaining to God's nature, especially His benevolence, while others identify tension between such benevolence and the Christian doctrine of the Atonement (i.e., the doctrine that Christ fully satisfied the demands of justice for human sins on the cross). While theologians in the past have sought ways to surmount these conflicts, contemporary defenders of the doctrine of hell favor setting aside the classical version in favor of an alternative.

According to a more liberal contemporary doctrine, hell is not a punishment for sin but a natural consequence of freely choosing to reject God's gracious offer of loving communion. The sufferings of hell are taken to involve nothing other than what necessarily follows from this free rejection of God. God, instead of imposing the sufferings of hell as a punishment, permits them out of respect for the free choices of the damned.

On this view, the damned are those who choose for all eternity to reject God's love, and the suffering of hell is nothing other than the experience of being deprived of every good that comes from union with God. Some contemporary religious thinkers, elaborating on elements of Dante's vision of hell, believe that such a state need not be as horrific as hell is ordinarily taken to be, because certain natural human pleasures, such as interesting conversation with others, might still be available to those who are alienated from God. Others, however, argue that alienation from God is alienation from the source of everything that gives interest and value to life, and is thus a state of total bereavement and anguish. Another concern is that the choice to reject the source of all that is good would only be made by those who suffer from a serious character flaw that, in the course of an eternal existence, would fundamentally compromise psychological health, leading eventually to the most debilitating inner torment.

Competing Doctrines of Hell

The most significant challenge for defenders of the liberal doctrine is to explain what could motivate the choice to eternally reject God's love, even though that choice supposedly brings only misery. While defenders of the doctrine cite pride or willful self-deception as playing a crucial role in such a choice, critics argue that no such motives could lead one to reject God's love forever, at least given the view that alienation from God is unremittingly and inconceivably horrible. Put simply, no one would choose the outer darkness if they really knew what they were choosing, and if they were truly free not to choose it. So if anyone is forever damned, it is difficult to make sense of how it could be purely a matter of free choice.

Some religious scholars argue that Christian theology as a whole makes no sense without a doctrine of hell. Unless there is a hellish fate to be saved from, the promise of salvation offered within Christianity loses its meaning. But this worry is largely vacuous. If a rescue team saves everyone from a sinking ship, the rescue has meaning even though all are saved. What gives it meaning is not that some are not rescued, but that many or all would have drowned without the rescue effort. Likewise, all that is needed to give meaning to Christian theology is a hypothetical hell, not an actual one: If human beings would suffer eternal alienation from God except for God's redemptive effort, this effort has meaning even if no one suffers such alienation. In fact, the redemptive effort becomes more impressive if it is universal in scope.

One of the most interesting issues pertaining to the doctrine of hell may be the impact that belief in this doctrine has on the living and the dying. At least one argument on behalf of the doctrine of damnation is that it encourages people to take moral norms and spiritual practices seriously in this life and to more fully appreciate the gravity of immorality and blasphemy and the urgency of moral reform. There is no doubt that the doctrine of hell has been invoked historically as a reason to diligently abide by the moral and religious teachings of Christianity (or an alternative faith as the case may be). A similar idea may apply to the dying: The prospect of damnation may motivate those who are vividly conscious of their mortality to seek to redeem their gravest failures in their final days.

However, it is debatable whether the doctrine of hell has these pragmatic benefits. Some clergy have noticed that the gravity of what the doctrine of hell promises is more likely to inspire either despair or denial and disbelief. The classical doctrine, in particular, has inspired hostile reactions through history, and is frequently cited by atheists as a reason for rejecting religious belief. Liberal theologians tend to point out that the image of a

wrathful and punitive God is more likely to inspire cowering servility or enmity than to inspire love and trust. If the aim is not merely to generate outwardly moral behavior but an inner attitude of loving devotion to God and His creation, it may be more effective to encourage feelings of gratitude rather than fear.

These last concerns may be partly avoided by the liberal doctrine of hell, which eschews the image of a wrathful God who punishes the unregenerate dead. But even in the case of the liberal doctrine, the gravity of what is purported to hinge on our free choices may have negative pragmatic effects. If avoiding damnation lies in one's own hands, one might be motivated to do one's best to make sound choices; but if a shattered self-esteem makes one skeptical of one's capacity to make such choices, the dire consequences that the doctrine of hell promises as the cost of failure may inspire despair.

Eric Reitan

See also Christian Beliefs and Traditions; Devil; Eschatology; Heaven; Last Judgment, The

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Hindu Beliefs and Traditions

Reincarnation is the archetypical belief and cremation is the archetypical practice for death among Hindus throughout India. This has been so for centuries, if not millennia. David Knipe explains the link between the belief in reincarnation and the practice of cremation. In one complete round of rebirths, the *Atman* (soul) makes five transitions, five being arguably the most sacred number in the Hindu worldview just as three holds that place in the West. The Atman travels from sky to earth by rainfall, from plants to men, from men to women, from women to bodily form, and by way of cremation back to the sky to begin the process anew. This account of reincarnation and the relevance of cremation to that process illustrate the holistic nature of the Hindu worldview in which humans are within the cosmos but are not viewed as having either the power or the right to fully control either their individual destiny or the environment.

The earliest references to Hindu death rituals are found in the *Rig Veda* and *Atharva Veda,* the Vedas being the oldest continuously used religious texts in the world. More detailed accounts are found in the *Garuda Purana*. In broad terms, the guidelines in these texts continue to be followed. However, there are also departures from those guidelines that reflect the passage of time and regional and local culture. Caste, stage of life, gender, and other factors, such as level of prosperity and makeup of the household of the deceased, also bear on the performance of death rituals. For example, someone whose job or income does not allow for him or her to perform the full set of rituals is not expected to do so. However, while some observers find no fault in such behavior, others may attribute any subsequent misfortune suffered within the family to failure to properly honor the deceased.

With regard to death rituals, the principle of *varna-ashrama-dharma* (caste stage of life-duty) is especially evident in the disposal of the dead by means other than cremation for certain categories of people. Corpses of young children and of *sadhus,* or holy men, are to be buried because they do not require the purification provided by *Agni* (fire both as a form of energy and as a form of god). The corpses of victims of epidemics or snakebites

are to be lashed to a bamboo stretcher and placed on a river, ideally the Ganges (a.k.a. Ganga). Explanations for these departures from cremation vary. By not burning the corpse of one who has died of disease, family members are said to avoid courting the wrath of the evil spirits who caused the person to die. By not burning the body of a snakebite victim and instead placing it in the care of Ganga, there is the possibility that the goddess Ganga might restore life to the individual.

Shraddha (Death Rituals)

Hindu death rituals serve the needs of both the dead and the living. For the recently deceased, the rituals remove pollution and facilitate the journey to *Yama,* Lord of the Dead, and to the next bodily form in this world. For the living, the rituals serve to remove the pollution they face on the death of a family member and help them to achieve peace of mind. In a larger sense, for all concerned, the rituals work toward restoring the balance that was disrupted by death.

As a family member approaches death, he or she should be placed to face east, the direction of the rising sun. Ideally, a dying person is given Ganga water from a *tulsi* leaf. Shortly after death, family members wash the body and place it in new cotton clothes, normally white. A woman who dies before her husband may instead be wrapped in red cloth, which symbolizes that she is married and was fortunate to die before being widowed. The thumbs of the deceased are tied together and so are the big toes; this prevents the limbs from shifting while the body is being taken to the cremation grounds. After receiving new clothes, the body is placed on the ground facing south, toward the abode of Yama. The family's *purohit* (Brahmin household priest) comes to the home, recites mantras, and lights an oil lamp at the head of the body. The lamp is kept burning throughout the mourning period.

A chief mourner, known as *dahak,* most often the eldest son of the deceased, performs rituals throughout the mourning period, which for higher castes is generally for 13 days. Custom allows for others to serve as dahak, depending on the makeup of the family. In principle, lower castes require longer periods to overcome the pollution brought on by death; however, their economic circumstances generally preclude lengthy and expensive rituals.

Cremation occurs within 24 hours of death. Before the body is taken to the cremation grounds, the dahak's head is shaved signifying that he is in mourning. In some instances, other men and older boys of the family may also have their heads shaved at that time. Traditionally, only men go to the cremation site, but nowadays sometimes women also attend. The dahak leads the way carrying a clay pot with burning incense. The mourning party carries the corpse overhead on a bamboo stretcher chanting *Ram nam, satya hai* (Ram is truth).

Before being burned, the body is taken around the funeral pyre counterclockwise three times. It is then placed on the wood and more wood is added to cover all but the head. The corpse is then given offerings of incense and ghee (clarified butter). The dahak, carrying a clay pot with water, makes three counterclockwise rounds of the site, and then throws the pot on the ground, breaking it. Then, without turning to face the body, he lights the pyre. To do this, he takes instructions from the *Dom* (low caste funeral priest). When the body is nearly cremated, using a long heavy bamboo rod and at a moment indicated by the Dom, the dahak breaks the skull. This act is known as *kapal kriya* (the rite of the skull). This is done in order to release the Atman (self). Nowadays, with the growing acceptance and use of electric crematoria, this ritual is slowly disappearing. (See further text for more details on Doms.)

After returning home, the mourners take a purification bath. In the place where the body was kept, an oil lamp is lit and kept burning to light the way of the departed soul. On the next day, the mourners return to the site to gather the "flowers" (remaining bits of bones and ashes), which they later deposit in a river, ideally the Ganges, so that these remains might be carried out to sea and the deceased will be in position to be reborn.

Throughout the mourning period, family members remain polluted and, in their impure state, various restrictions apply, especially to the dahak. He is to sleep on the ground and does not leave the home except to perform other *shraddha* rituals. During the mourning period, cooking within the home is forbidden; the family eats only pure, or *satvik* (vegetarian and without onion or garlic) food brought in from outside the home. During the days of impurity following a death, it is customary for the family to eat foods especially liked by the

deceased and to offer *pindas* (rice balls) to three or more generations of the ancestors, with particular emphasis on male ancestors. Additionally, in many households, during their days of pollution following the death, the family members bathe in water but without using soap, and they do not clean the house. The men do not shave or cut their hair, and family members do not cut their fingernails or toenails. After a death as well as a birth, married individuals, polluted by either the arrival or departure of a family member, avoid worship of the gods until a prescribed number of days (typically 12) have passed.

On the day after cremation, the dahak is joined by another funeral priest known ironically as *Mahabahmin* (Great Brahmin), also known as *Mahabrahmin* and *Mahapatra*. Understood to belong to a branch of Brahmins who disgraced themselves in the distant past, the Mahabahmin performs only certain death rituals and does not serve on other occasions. He and the dahak perform *pinda daan* (feeding ancestors with rice balls) and place a clay pot with a small hole in the bottom in a pipal tree on the outskirts of the inhabited area. This ritual is known as *ghant bandhana* or *ghant matkana* (to tie the pot and to hang the pot). *Ghant* literally means "Adam's apple." The dahak returns daily through the 10th or 13th day to fill it with water. The *prêt* (unsettled spirit) retains some bodily needs, including need to quench its thirst, during the shraddha period. However, lacking bodily form, it cannot alight on the ground or a body of water to drink. The water dripping from the clay pot serves its needs. At the conclusion of these rituals, the Mahabahmin decides when the prêt no longer needs water and instructs the dahak to break it using a sturdy bamboo pole. This is regarded as a potentially dangerous task. This is because the prêt depends on the dahak and Mahabahmin; if the rituals are not performed in a timely manner, the prêt may become angry and attack either of these individuals. On the last day, for his services, the Mahabahmin is given cash as well as many of the possessions of the deceased, such as the cot, clothes, and sometimes more valuable items, but not possessions of sentimental value.

The 10th day marks the end of the family's pollution period. The family now takes a ritual purification bath and, within some families, the heads of men and older boys are shaved. Nails of family members are now cut. The family cleans the home for the first time since the death. On the 11th or 12th day the family hosts a meal on behalf of the deceased. The preferred date and details of these closing rituals of mourning differ from region to region. Even within a given region, there are variations, due in part to migration with many families continuing to practice the specific rituals of their place of origin. Pinda daan is given to the deceased and at least two other generations of the ancestors in order to ritually unite the Atman with the ancestors in the next world. Pinda daan is followed by a ritual meal called *Brahmin bhoj* (feeding Brahmins). The traditional number of Brahmin priests should be 12, but in actual practice the number varies depending on the economic conditions of the family, local customs, and the availability of Brahmin priests. The Brahmins are also given cash and clothes. In earlier times, and to some extent even in rural areas today, some wealthy, higher caste families give their purohit a female cow, which he in turn is understood to make available to the deceased. This act is known as *go-daana* (gift of a cow). The prêt is to hold onto the tail of the cow and thereby be transported across the Vaitarani River, a parallel to the River Styx, and across the *Kshira Sagara* (cosmic ocean of milk). On reaching the other side, the Atman is in position to begin again the cycle of rebirths.

On the 13th day the dahak represents the family and accepts alms from many guests who attend a special meal to mark the end of the mourning period and to welcome the family back into society. Another male member of the family records the names of the givers and amounts in a notebook, which is consulted in the future in order to provide compensatory support when there is a death in others' families. This practice bolsters bonds with friends and acquaintances outside the extended family and constitutes an efficient folk insurance system, one lacking any middleman or hidden costs. The death rituals are now at an end, but acknowledgment of the death may continue in several ways.

On the 31st or sometimes 40th day, pinda daan is performed with some portions given to three kinds of animals—crow, cow, and fish. This is an abbreviated form of the rituals of the 11th day and is done to unite the recently departed with the ancestors and to further mark the end of the ritual impurity. These rituals may also be performed on

the 11th day and not repeated on the 31st. However, some families perform pinda daan each month for one year. For example, in West Bengal, *masika* (monthly) *shraddha,* centered on pinda daan, is performed for one year. Alternatively, families preferring a streamlined agenda perform much the same rituals but called *samvatsarika shraddha* after 6 and 12 months. After 12 years, preferably either during *shraddha paksh* or the fortnight corresponding to the 12th anniversary of the family member's death, the bereaved visit Gaya in Bihar, a famous pilgrimage center associated with honoring the ancestors, to perform pinda daan.

In North India, in earlier times, a brief ceremony known as *barsi* involving ritual feeding of the ancestors was performed on or close to the first and second anniversary of a death. The combination of the shraddha rituals at the time of death plus the two rounds of barsi served to help the individual achieve peace in successive levels of the cosmos—earth, sky, and heaven. Nowadays, it is common for the barsi rituals to be folded into and performed at or near the conclusion of the shraddha rituals.

For one year, the family and especially the dahak are to avoid participating actively in celebrations: No weddings, housewarmings, and so forth are to be performed. However, it is now common for friends of the mourning family to coax them into joining them to participate in *Holi* and other festivals if only in minor ways. In this way, the dead remain honored and the living help each other to move on.

Shraddha Paksh (Ancestors Fortnight)

Annually during *Ashwin krishna paksh* (the dark fortnight of *Ashwin,* corresponding to September-October), the ancestors are remembered and honored. Pinda daan in the home with Brahmins in attendance is performed. Afterward, foods known to have been preferred by various ancestors are served to the Brahmin purohit, who also receives gifts of clothes, fruit, and cash. If there has been a death in the past year, the purohit will come on the day of shraddha paksh corresponding to that of the death of the recently departed. If more than one family member has been lost in recent times, the family may hold rituals on each of those days. In any event, it is customary for all families to participate in shraddha paksh on the last day, *amawasya* (new moon day), of the fortnight to show respect for all of their ancestors, including young children who may have died and ancestors whose date of death is no longer known.

In keeping with the long process of death rituals previously outlined, during which time the prêt remains unsettled, that is, it remains an active, albeit unseen, participant in this world. This belief has given rise to widespread belief in attacks by spirits of the dead and, in turn, to a range of exorcists of whom the *Aghoris,* a sect headquartered in Banaras, are deemed to be the supreme practitioners. In eastern Uttar Pradesh and western Bihar, there is widespread belief in *Brahms,* spirits of Brahmins who died either by accident or murder. At first those spirits are considered to be potentially angry. Initially, they may be propitiated, but in time worshipped if individuals honoring a Brahm come to attribute any good fortune to him or her. As worship replaces propitiation, a Brahm may evolve into a godling with widespread following and even an associated day of week for devotees to visit the site associated with him or her.

If and when a soul achieves complete peace so as to experience *moksha* (release from the cycle of rebirths), the individual Atman joins and becomes part of the universal Atman. This outcome may occur for truly exceptional, saintly individuals, but it is more of an ideal to aspire to rather than a goal that common people look to achieve.

The Doms

Dom carries two meanings: the caste of funeral pyre tenders and the occupation of funeral pyre tending. Throughout northern India, Doms occupy the lowest or among the lowest rungs of the caste hierarchy, the challenge for that rank coming only from *Bhangis* or sweepers, particularly those who clean toilets. One Dom in Ballia District of eastern Uttar Pradesh, in imagery recalling Atlas holding up the world, has proudly stated, "We are the lowest of the low." He went on to explain that all other castes benefit by having the Doms as a baseline against which to assess their position in the caste hierarchy. He suggested that beyond being indispensable in death rituals, Doms are implicitly present throughout the entire lifespan due to the part they play in defining the social structure. Historically, Doms have occupied such a low position because

their job is both polluting (the corpse) and dangerous (the risk of courting the wrath of the prêt should the rituals not be performed correctly).

It is interesting that entry into this life is also overseen by a low caste functionary, the *Chamain* (meaning woman of the leatherworkers' caste and midwife), whose duties are also seen to be both polluting (blood) and dangerous (risk of death of the mother or baby). Of these two critically important low caste functionaries, only the Dom is reviled. One cannot be sure that he has successfully performed his duties at every cremation he has overseen. By contrast, the midwife's success is evident in the survival of the children she has delivered. Moreover, although for decades nearly all deliveries have been in hospitals, even in fairly recent times, low caste midwives have commonly served as wet nurses for the infants of higher caste women and have been affectionately dubbed *Chachi* (Auntie) by the older children they have delivered. Such intimacy with Doms is unthinkable. It is worth noting that the sequence of cool-hot-cool of the death rituals (giving Ganga, cremation, placing the ashes in water) is paralleled by the low-high-low status of the functionaries overseeing the three major events in life—low caste midwife for birth, high caste Brahmin purohit for wedding, and low caste Dom for cremation.

Banaras, or Varanasi, has the most sacred Hindu cremation grounds in all of India. The Dom Raja (King of the Doms) lives in an immense home beside one of the burning ghats. As the ranking member of a hierarchy of funeral pyre tenders, the Dom Raja is quite wealthy. Immediately below him are the foremen who oversee the third tier, the workers who serve at the cremation fires. Access to any of these positions is a birthright resting on membership in particular families of the Dom caste. Men of families employed at the cremation grounds in Banaras have clearly defined entitlement to particular fire sites and particular days of week.

In Banaras, hierarchy of Doms is mirrored in a three-tier prestige hierarchy of sites. One or two funeral pyre sites are reserved for high-ranking individuals whose families are able and willing to pay much higher fees to the Doms. The vast majority of cremations take place at the ordinary sites at the two cremation grounds in Banaras. An electric crematorium is a third option and is now used throughout urban India.

Elsewhere in northern India, especially in villages and small towns, Doms also have an inherited privilege to serve in that capacity at particular places but without the elaborate hierarchy found in Banaras. In keeping with the custom of individuals of low ranking castes enjoying temporary elevation into honorific positions, throughout much of northern India, Doms lead processions while playing a curved copper horn known as a *singha* for Kali Puja and on other festive occasions. The Doms of Banaras do not play the singha and are not even aware of its association with their caste. Its absence from Banaras and collective memory is due to the high volume of cremations and the sacredness of those cremation grounds. Thus, the Doms of Banaras have neither the time for peripheral ceremonial duties nor, despite their low rank in the broader social structure, the need to seek higher status. The most sacred of India's cremation grounds can be said to confer on them the rank of "highest of the lowest of the low."

Bradley R. Hertel

See also Eschatology; Eschatology in Major Religious Traditions

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HIV/AIDS

HIV/AIDS is an acronym that stands for human immunodeficiency virus/acquired immune deficiency syndrome. HIV is a retrovirus and AIDS is the disease a human experiences when the HIV virus reaches an advanced stage. There are two species of HIV that infect humans: HIV-1 and HIV-2. HIV-1 is more easily transmitted than HIV-2 and is the cause of the majority of HIV infections worldwide.

The HIV virus weakens the immune system of its host to a point in which individuals may acquire certain infections, such as tuberculosis, cryptococcal meningitis, and severe pneumonias, which are termed opportunistic infections. These opportunistic infections are life threatening and cause death in the majority of AIDS patients who don't have access to treatment. For many years in many parts of the world and for millions of people still today, acquiring HIV/AIDS translates into death a few years later.

The first AIDS cases were identified in the United States in 1981, followed by those in Uganda the next year. Early on, the condition was also nicknamed "slim disease" because advanced HIV infection causes severe bodily wasting. The early stages of the epidemic were characterized by baseless finger pointing in an attempt to identify particular individuals, communities, cultures, and lifestyles as responsible for the spread of HIV. Haitians, homosexuals, and Africans received the largest burden of unfounded blame.

The current estimates are that 33.2 million people are living with HIV/AIDS. It is believed that the number of new infections peaked in the late 1990s, yet in 2007, there were still 6,800 new HIV infections each day, totaling 2.5 million new infections during the past year. HIV/AIDS is among the leading causes of death worldwide and the number one cause of death in sub-Saharan Africa, a region that has disproportionately borne the burden of the epidemic. Cases have been reported in all regions of the world, but more than 95% of those living with HIV/AIDS are in low- and middle-income countries. Beyond Africa, the second-most-affected region is the Caribbean, followed by growing concern in parts of Eastern Europe and Asia.

Social Causation of Disease

HIV/AIDS can be transmitted through any of the following modes: sexual transmission (e.g., unprotected oral, anal, or genital contact with another person's infected sexual secretions), shared injection drug use paraphernalia, mother to child transmission, and blood-to-blood contact. These modes of HIV transmission are well known and lead to the conclusion that HIV/AIDS is entirely biologically preventable. Yet both epidemiological and sociological accounts have drawn attention to the social factors that make transmission of the disease more likely in particular communities given their social location. Clearly there are important social, economic, and political factors to take into account when understanding this condition, its prevalence, as well as its transmission and treatment. Poor and marginalized people are more likely to contract and die from the disease than those with access to material resources. Gender discrimination, poverty, and political repression are all examples of social factors that can disadvantage certain populations and create increased vulnerability to the disease.

Relationship to Gender

Gender is an important social causation to be taken into account when considering HIV/AIDS. Globally, women are 50% of all adults living with HIV/AIDS, and in sub-Saharan Africa they make up 61% of all people living with HIV/AIDS. There are several reasons for this. One is that women are biologically more susceptible to HIV infection than men due to their anatomy. Yet an even greater gender factor is gender inequalities in social and economic status. These inequalities may increase the likelihood that women will contract the virus because they may lack the power to refuse sex. Additionally, sexual violence against women, such as rape or other forms of sexual abuse, may also increase their vulnerability to acquiring HIV/AIDS, especially in areas where the epidemic already has a high prevalence in the general population.

Relationship to Poverty

Poverty is another factor that plays into the transmission of HIV/AIDS in several ways. First, when

individuals and families are economically poor, they often have less resources and opportunities that can be drawn upon for household income. In such contexts, poor people may partake in certain behaviors to secure income, such as transactional sex, which exposes them to greater risk of HIV/AIDS transmission. Second, the poor also often lack access to safe water, nutritious food, and quality health care—three components that are critical for ensuring that their bodies can defend themselves from deadly opportunistic infections.

Relationship to Political Repression

Political repression as a social causation of disease refers to policies and regimes that oppress particular populations and make them more vulnerable to infection. This concept can also be called structural violence. Policies of forced displacement by either governments or international agencies are one example of the ways in which the policies and conduct of institutions can limit the livelihoods of and access to social services for particular populations. Another political factor that is related to the social causation of HIV/AIDS is international drug patent and pricing. These international policies often prioritize profit of drug developers and manufacturers over guaranteeing that those who are sick and need the medication have access to the lifesaving medications. This translates into inadequate care and treatment options for particular populations, which can lead to more HIV/AIDS infections.

Behavioral Analysis

Another factor that is important to take into account for understanding the causation of HIV/AIDS is particular behaviors that individuals undertake, which significantly increase their risk of infection. Such risky behaviors include taking drugs with unclean needles or practicing unprotected sex. Many AIDS prevention programs attempt to address this through behavior change efforts. Such programs place emphasis on educating individuals and groups about the negative effects of particular conduct, and then encouraging people to change their behaviors by participating in needle exchange programs, being monogamous in their sexual relations, and using condoms and dental dams.

Responses to the Epidemic

Responses to HIV/AIDS have broadly fallen into three categories: prevention, treatment, and care. Prevention generally includes education about the disease as well as how one can prevent transmission of HIV/AIDS from one person to another. As previously noted, these various forms of prevention are often termed behavior change efforts. One popular model is the "ABC Model," where A stands for *abstinence,* B is for *be faithful to one's partner,* and C signifies *condom use*. Harm reduction programs operate on the theory that people will sometimes participate in risky activities, yet these people ought not be punished for this; rather, they should be given the tools to prevent infection. One example of a harm reduction program is one that offers needle exchange options. Examples of other prevention programs include medical services for pregnant women and newborns and centers for testing and counseling. Others work to prevent HIV/AIDS through more advocacy-based approaches, which strive for structural change to address underlying social causations and inequalities, such as drug pricing or poverty. And finally, some have demonstrated that ensuring treatment for those with HIV/AIDS is a form of prevention in itself. When people know that medication is available for treatment, it encourages people to get tested and know their HIV status, which, in turn, leads to preventing the transmission of the virus. Additionally, HIV that is well controlled with treatment is less likely to be passed along to another individual.

Treatment for HIV/AIDS is accomplished through medications called antiretrovirals (ARVs). ARVs do not cure a person of HIV or AIDS, but they can help people with HIV live nearly normal lives by reducing the amount of HIV virus in the blood. This helps an individual's immune system work properly and fight off other infections. Individuals only take ARVs when they develop a serious HIV-related illness (opportunistic infections) or when their CD4 (cells that control one's immune system) count drops significantly. For the majority of people, this happens approximately 8 to 10 years after infection. The first ARV was called azidothymidine (AZT), which was a cancer medication that was found effective against HIV. It was introduced as a way to treat HIV/AIDS in

1987. In 1996, highly active antiretroviral therapy (HAART), which entails combining different classes of HIV drugs for a more potent effect, was introduced. It is also called the "triple drug cocktail" because generally it combined three forms of medication into one treatment therapy. After HAART became available, AIDS death rates dropped drastically in the United States and other countries where people could afford the drugs.

Beyond ARV treatment, treatment also exists for opportunistic infections. This includes treatment for sexually transmitted infections, tuberculosis, specialized forms of pneumonia, brain infections, and herpes. These forms of treatment are often used alongside ARVs and were available long before ARVs.

Care responses for HIV/AIDS include ensuring that food security and proper nutrition are available for people living with the virus and disease, as well as psychosocial support and care for HIV/AIDS patients and their families. Furthermore, availing ongoing prevention services to ensure that those already with HIV/AIDS do not transmit the virus is a component of care that is also important.

Global and Local Responses

Within the framework of prevention, treatment, and care, there have been global and local responses to HIV/AIDS. Globally, the United Nations has stressed HIV/AIDS as a global challenge deserving serious attention. The Joint United Nations Programme on HIV/AIDS (UNAIDS) was established in 1994, and the Security Council passed resolution 1308 in 2000, acknowledging HIV/AIDS as a global security threat. One of the major multilateral initiatives has been the Global Fund to fight AIDS, tuberculosis, and malaria. The Global Fund was established in 2002 as a public-private approach to prevention, treatment, and care in 93 countries. In 2004, the United States began an AIDS program called the President's Emergency Plan for AIDS Relief (PEPFAR), which translated into $15 billion toward the global AIDS pandemic.

On the local level, communities have come together to educate one another to prevent infection, offer counseling and psychosocial support to those with the condition, provide primary health care for opportunistic infections, care for orphans left behind by deceased family members, advocate for access to medications, and ensure that nutritional needs are met. One innovative response has been the formation of groups and networks of people living with HIV/AIDS. These groups provide unique opportunities for people already living with the virus or directly affected by it to play a proactive role in curbing the epidemic. Several of these community-based groups sprouted in Africa in the 1980s and 1990s.

One of the most well known community-based responses to HIV/AIDS is The AIDS Support Organisation (TASO), which was founded in 1987 in Uganda. Unified by common experiences of stigma and discrimination, the founders, people who had been impacted by HIV/AIDS in various ways, began informally meeting in each other's homes to offer social support and encouragement. These types of efforts have contributed significantly to eliminating stigma and discrimination of those who have HIV/AIDS. This was vital because earlier in the epidemic many myths were circulated about HIV/AIDS and its transmission. Many people were afraid to have any physical contact with individuals who had HIV/AIDS, and many who had the disease lost their jobs. Over time as the truth about transmission has become more prevalent, stigma and discrimination has reduced.

Another group that is largely composed of individuals who are living with HIV/AIDS is the Treatment Action Campaign (TAC) in South Africa, which has unfolded into a network of over 10,000 people who have had success in putting HIV/AIDS on the public agenda in South Africa and beyond. They are especially known for their role in pressuring drug companies to drop their case against the South African government on issues related to generic drugs and for rolling out the South African government's HIV treatment program. Similarly, ACT UP in the United States has also contributed significantly to reducing stigma and carrying out political advocacy campaigns to fight HIV/AIDS.

As demonstrated by the array of responses, HIV/AIDS directly affects those affected by the disease as well as family and community members who are around those with the disease. In communities where HIV/AIDS prevalence is high, many sectors of society can be heavily impacted. As working-age populations become sick and are unable to work, production and consumption are affected, thereby

disrupting economies. Education sectors also suffer as teachers become ill and are no longer able to teach. Many pupils who have HIV/AIDS themselves or whose family members are sick are also prevented from attending school due to not feeling well themselves, needing to take on additional chores at home, or for being unable to pay school fees. Obviously, the health sectors are also affected in communities with high prevalence of HIV/AIDS. The public health and primary care infrastructure becomes overwhelmed. Additionally, many countries lose large numbers of health workers to the disease itself, as well as the fact that many workers don't want to work in contexts where vast amounts of the population are dying.

AIDS and Death

In communities with high prevalence rates of HIV/AIDS, death becomes a more apparent part of society. HIV/AIDS affects national mortality rates, life expectancy, and population growth. In some countries in southern Africa, where prevalence is between 15 and 30% of the adult population, communities strive to cope with mass amounts of illness and death. Funerals and burials become regular social occasions. Furthermore, in such communities the mental health of survivors can be greatly affected. A recent study in rural Uganda conducted in 2000 through 2001 revealed a depression rate of 21% in two districts where HIV/AIDS prevalence was extremely high. This level of depression obviously affects all sectors of society and the capacity of members of the community to plan for the future. Beyond mental health concerns, HIV/AIDS also lowers the life expectancy significantly. In some sub-Saharan African countries, life expectancy has decreased to 40 years due to HIV/AIDS.

Looking Ahead

Every two years, thousands of clinicians, academics, community health and social service providers, aid agencies, students, and activists gather at the International AIDS Conference hosted by the International AIDS Society. At these meetings, historical debates are hashed, cutting-edge research is presented, and innovative social programs are showcased. These meetings also highlight some of the themes that are on the horizon in the field of HIV/AIDS, which includes the development of a preventive AIDS vaccine, of which there is extensive research and significant hope invested but no solid results yet. A preventive AIDS vaccine would work by training the body to defend itself against a pathogen by introducing an immune response. Thus, when someone actually acquired the infection, his or her body would be able to fight it. Related efforts are increasingly directed toward microbicides, which are compounds, often gels or creams, that one applies inside the vagina or rectum to protect against HIV. There are several forms that are at various stages of clinical development. Finally, efforts are increasingly being directed at expanded forms of treatment of HIV/AIDS. New drugs are frequently being introduced and tested through clinical trials to overcome drug resistance and reduce side effects, providing hope that more efficacious forms of treatment may arise.

Amy C. Finnegan

See also Economic Impact of Death on the Family; Life Expectancy; Orphans; Sex and Death

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Holidays of the Dead

Holidays of the dead were and are present in many various cultures and religious traditions around the world. They can be both of religious character as well as secular. Contemporary holidays and festivals of the dead have their origins in ancient rituals and beliefs. The two most well known and popular are: Halloween, especially popular in the United States but also found across contemporary Western civilization, and *El Día de los Muertos*, originating in Mexico. Other, lesser known examples are Christian All Saints' and All Souls' Days, *Bon Festival,* which is a Japanese Buddhist custom, and the Vietnamese festivals *Thanh Minh* and *Tet Trung Nguyen.* All of these have their sociological (corporate and psychological) and individual dimensions and functions (e.g., building and sustaining the self-identity, coping with loss, and integration with local community). Each of the previously mentioned holidays will be considered from three main aspects: history and/or ancient roots, beliefs, and rituals.

All Saints' and All Souls' Day

According to Roman Catholic tradition, the 1st of November is All Saints' Day and the 2nd of November is All Souls' Day in the religious ritual calendar. The former is devoted to the commemoration of all Catholic saints, who at first were usually martyrs. The holiday arose from the tradition of solemnizing the martyrs in Christianity and the commemoration of Christ's martyrdom. We find the first traces of this tradition during the days of the early Christian church in Antioch, on the Sunday after Pentecost. At first only martyrs and Saint John the Baptist were honored by a special day, but gradually, other saints were added to the religious calendar. Pope Gregory III (731–741 C.E.) consecrated a chapel in the Roman Basilica of Saint Peter to all the saints and fixed the date for communal commemoration to the 1st of November, when Catholic churches hold special masses. This day is now a national holiday in some countries (e.g., Poland).

All Souls' Day is focused not on those in heaven, as is the case of All Saints' Day, but on those in purgatory, which according to Catholic teaching are the average believers. The belief underlying this holiday is that the prayers of the living, on behalf of the dead, can help the dead achieve salvation and go to heaven. On this day, all the masses are requiem, dedicated to the dead; believers donate to the Church for the sake of salvation of the souls in purgatory. The ritual also involves visiting cemeteries and gathering together and praying beside the graves of family, friends, famous people, and national heroes. People decorate the gravesites with lit candles, flowers (chrysanthemums usually in Central and Eastern Europe), and wreaths. The general character of this holiday is rather sad, full of grief, and pathos. This Catholic tradition goes back to the sixth century Benedictine monks who decided to offer the mass on the day after Pentecost for their deceased community members. In 998 C.E., Odilo, Abbot of Benedictine monastery in Cluny, changed the date of their commemorative mass to the 2nd November, the day after the Feast of all Saints. This custom spread, and in the 13th century, Rome put the feast on the Church calendar.

Before Christian times, in late October/early November in the region of today's Eastern Poland and Lithuania, there was a Slavic pagan tradition of *Vėlinės* or *Dziady*, a week-long holiday of the dead. It was believed that during this time each year, the souls of the dead leave the afterlife world and come back to visit their family and home.

People gathered in cemeteries and visited the graves of family and friends. Bringing milk and beer, they danced and feasted for several days. The holiday was also celebrated at home with a huge supper for the whole family. Afterward the food was left for a night on a table for the deceased, and then given to the poor and homeless a day later. Some aspects of these holidays were incorporated into the later Christian rituals of All Souls' Day introduced in these regions during the 12th century. In this part of world, All Souls' Day is a holiday commemorated by nonbelievers as well as Christians.

Halloween

Celebrated on the 31st of October, the name of this holiday comes from All Hallow Even (the eve of All Saints' Day). Irish immigrants in the 19th century brought this holiday to the United States, and from there it spread throughout the West, although it is still more popular in the United States. This holiday arose from the fusion of the pagan Celtic tradition of *Samhain* (or *Samuin*), the Christian All Saints' and All Souls' Days, and the introduction of the last into Pagan territories. Samhain was a celebration of the end of summertime, probably devoted to Saman, god of the dead.

The belief underlying this holiday is that the Halloween night belongs to the dead, who emerge from their graves and wander the roads, the sea, and every other area. The border between the two worlds, of the living and of the dead, is particularly vague and indefinite on this night, thus the communication and exchange between the two worlds is present. The ritual involves, as an example among a wide range of activities, "tricking or treating," where children disguised as skeletons, ghosts, and so forth go from house to house saying "trick or treat"—looking for sweets and organizing costume parties. Many of the elements and symbols of Halloween are now found around the world, and it is also a rich source of pop culture themes used in movies, music, and literature. The general character of this holiday is joyful, full of happiness, parties, and laughter.

El Día de los Muertos

El Día de los Muertos (The Day of the Dead) is the Mexican name for All Saints' and All Souls' Days, which are celebrated on the 1st and 2nd of November. It is the most important celebration ritual in the Mexican calendar. The underlying belief of this holiday is that the souls of the dead return to the living and reunite with their relatives and friends. Crucial for the feast are the days between October 31st and November 2nd, when offerings, food, and drinks are presented to the dead. El Día de los Muertos in Mexico is a private and family feast rather than a public one. The ritual involves building a special altar for the dead (*la Ofrenda*) in the home. La Ofrenda usually consists of boxes put on a table and covered with white cloth or paper, sacred images of Jesus or Saint Mary, photographs of the deceased and things that remind the family of the deceased in some way, a candle for each spirit, as well as sugar *calaveras* (skulls) and the *pan de muerto* (bread of the dead). When the altar is ready, the dead are called home and welcomed to many hours of companionship with their living relatives and friends. At midnight on October 31st, an elaborate banquet, called *Hanal Pixal* (dinner of the dead), is served for the spirits of the deceased and the living.

El Día de los Muertos is also celebrated in cemeteries. Graves are cleaned and decorated with marigolds (flowers of the dead in Mexico), offerings of copal (resin incense), candles, calaveras, and food. Family members may take turns or all may stay by the grave the whole night to spend it with the spirits of their dead relatives and to share the foods with them. The general character of this holiday is a mixture of sadness and solemnity, caused by the memory of the death of the deceased, with feasting and enjoying their temporary return. The holiday in Mexico arose as a fusion of Christian and pre-Hispanic elements of tradition.

Bon Festival

Bon (*Obon* or *Urabonne*), the Feast of Lanterns, is a Buddhist holiday that takes place in Japan between August 13 and 16 (according to Solar calendar) or July 13 to 16 (according to Lunar calendar). Its underlying belief is that, during this time, the spirits of the dead come back to their former homes to reunite with their families. The Buddhist myth, on which the holiday is based, tells the story of Mokuren, a disciple of Buddha, who used his supernatural power to look upon his dead mother. He saw her great suffering in the Realm of Hungry

Ghosts and asked Buddha for help. He was told to make some offerings to the priests just finishing their summer retreat. Mokuren followed Buddha's instructions and as a result his mother was released.

Before this holiday, people clean their houses and prepare them for a visit of special guests. They also clean the gravesites. The ritual involves special Buddhist services held in temples and houses of ancestors, dead relatives, and friends, particularly for those who died in the last year. Apart from Buddhist services, the celebrating of Bon includes visiting gravesites and a ritual supper in which the spirits of the deceased are believed to take part. The spirits are led from their graves to their family homes with lanterns and then are given food, flowers, and incense. Another part of the Bon celebration is a ritual dance—*Bon Odori*—performed by people in front of temples and in town squares. The dance commemorates the joyful dance of Mokuren. The festival ends with the floating of the lanterns—*Toro Nagashi*. Lanterns symbolize the spirits of the deceased; they are lit and then floated down rivers. This part of the ritual symbolizes returning the spirits to the world of the dead. The ceremony culminates with fireworks.

Over time Bon evolved from a religious holiday into a family holiday, when families reunite and people return to their family homes and commemorate the dead. It is a religious holiday, but it is also a joyful social occasion. Some of its elements (date, music, and dance) vary according to the region, but the major functions and mythical origins stay the same. The Bon holiday is celebrated also in other parts of the world (e.g., Brazil, Malaysia, United States, and Canada) in Japanese communities.

Thanh Minh and Tet Trung Nguyen

Thanh Minh is celebrated on the third lunar month. A few days before the holiday, family members clean the gravesites and paint the tombs. The ritual involves visiting the graves of ancestors to commemorate them and to offer flowers, food, votive papers, and incense to the dead.

The other important holiday of the dead in Vietnam is Tet Trung Nguyen (Wandering Souls Day)—the second largest festival in this culture. It is celebrated on the 15th day of the 7th month, but it can also be held at any other convenient time during the 2nd half of the month. The underlying belief of this holiday is that after death, the soul is judged and afterward sent to heaven or hell as a reward or punishment for his or her life. This holiday is the best time for prayers for the sake of condemned souls. On this day, it is believed the gates of hell are opened and the hungry souls fly out in search for food. Souls that have living families or friends go home and find what they need on their family altars, but those who have no families or who have been forsaken by the living are doomed to wander helplessly. They are the "wandering souls" in need of food and prayer. Public altars full of offerings are built in pagodas and many other places for the use of wandering souls.

The main celebration takes place in open air or in the largest room of the house (so it can hold many wandering souls). During the ceremony, tables are covered with offerings: three kinds of meat, five kinds of fruits, and other foods, such as rice cakes, soup, and meat rolls. The ritual also involves burning money and clothes made of votive papers.

Małgorzata Zawiła

See also Ancestor Veneration, Japanese; Day of the Dead; Ghosts; Halloween

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HOLOCAUST

The Holocaust was the systematic extermination of more than 6 million European Jews, perpetrated

by Nazi Germany between 1939 and 1945. The event is also known as the *Shoah* or "annihilation" in Hebrew and as *Churban* or "destruction" in Yiddish. The Holocaust has certain features that distinguish it from other human catastrophes: It resulted from centuries of religious and philosophical hatred of the Jews, and it was implemented as the official policy of a modern state. Perhaps most significantly for how one understands death and the human experience, the Holocaust was an act of mass murder that rested upon a fundamental view of the value of a human being, a view that was in direct conflict with the teachings of Jewish tradition. In the following text, a brief historical background, some historical highlights of the Holocaust, and some ramifications of the Holocaust for understanding death and the human experience are presented.

Historical Background

The hatred of the Jewish people that paved the way to the Auschwitz extermination camp has its roots in the early centuries of Christianity. According to Saint Ambrose (ca. 340–397), it was not a crime to burn synagogues. Saint John Chrysostom (347–407) described the Jews as enemies of God and was among the first to accuse the Jews of deicide. While Saint Augustine (354–430) recognized the Jews as witnesses to the truth of the Hebrew scriptures, he viewed their exile as a divine punishment for rejecting Christianity.

The first large-scale murder of the Jews at the hands of the Christians took place during the First Crusade in 1096, when thousands of Jews were slaughtered in the Rhineland. The widespread slaughter of the Jews continued in England in 1190, in Germany in 1348–1349, in Poland and the Ukraine in 1648–1649, and in the 1880s and 1903–1906 in Russia. Throughout these centuries, Jews were labeled agents of Satan, desecrators of the Host, sorcerers, and vampires. In 1290, they were expelled from England, in 1394 from France, in 1420 from Austria, in 1492 from Spain, in 1496 from Portugal, in 1512 from Provence, and in 1569 from the Papal States. Indeed, Jews were expelled from almost every country in Europe.

With the coming of the Enlightenment in the 18th century, the philosophical anti-Semitism of the intellectuals was added to the theological anti-Semitism of the Christians. Nearly all of the great philosophers of the 18th and 19th centuries—including Voltaire, Immanuel Kant, Johann Gottlieb Fichte, G. W. F. Hegel, Arthur Schopenhauer, and Friedrich Nietzsche—delivered diatribes against the Jews. In addition, the advent of modern scientific method brought with it theories that associated character traits with biological origins, from which arose modern race theory. Thus Nazi ideologue Alfred Rosenberg maintained that humanity was being poisoned not only by Jewish blood but also by Judaism because the –ism is in the blood. The Nazis' annihilation of the Jews was based on an all-encompassing worldview that targeted both the Jews and Judaism for extinction. Because the Nazis' chief instigators were thoroughly versed in modern philosophy, science, and cultural history, they were able to use that expertise to suit their own ends. The Holocaust, then, was not the work of lunatics and hoodlums; rather, it was conceived and carried out by some of the world's most highly educated people.

In keeping with a major line of philosophical development from the Enlightenment onward, the Nazis sought the destruction of the God of Abraham and everything He signifies through the destruction of God's chosen. It is perhaps startling but certainly not surprising, then, to discover that by 1940, nearly half of the intellectuals of Germany—doctors, attorneys, and professors—were members of the Nazi Party.

On November 9, 1919, one year after World War I had ended, the Weimar Republic was born. Disgruntled over Germany's loss of the Great War, many Germans joined anti-Semitic right-wing groups, such as the Thule Society. In January 1919, the Society founded the German Workers' Party. By the time they took the name National Socialist German Workers' Party on February 24, 1920, Adolph Hitler had ascended to the leadership of the Party. On January 30, 1933, after the Nazis had won more seats than any other party in the parliamentary election, he was appointed Chancellor of Germany.

Fueling the Nazis' rise to power were not only centuries of Jew hatred but also years of hardship that befell Germany after World War I. Many Germans blamed the Jews for Germany's humiliation in the Treaty of Versailles. In addition, the first years of the Weimar Republic were marked by

runaway inflation. In January 1921, 64.9 marks were the equivalent of 1 U.S. dollar; in November 1923, 4.2 trillion marks were the equivalent of 1 U.S. dollar. The late 1920s, then, saw an increase in the popularity of the Nazi party, who promised to do something about Germany's humiliation and its economic condition. With the onset of the Great Depression in 1929, a catastrophe that affected the entire world, the Nazi Party appealed to more and more people, until they won more seats than any other party in Germany's parliamentary elections of November 1932.

By the end of March 1933, the concentration camp Dachau was in operation, a camp initially opened to detained enemies of the Nazi Party. In that year, a series of laws were passed to begin the project of legislating the Jews out of German society: Everything done to the Jews in Nazi Europe was legal under the law of the Third Reich. The year 1933 also brought for the Nazis their first diplomatic recognition, with the Vatican Concordat of July 20. On September 15, 1935, the infamous Nuremberg Laws were passed, officially defining a Jew as anyone with a Jewish grandparent (with the Jewish grandparent being defined as anyone who belonged to a synagogue); the laws also defined as a Jew anyone who had converted to Judaism, thus making it clear that the ultimate target was both the Jews and Judaism. By 1939, numerous other camps had been opened, including Buchenwald (1937) and Mauthausen (1938).

The Holocaust

On the night of November 9, 1938, the date that many designate as the beginning of the Holocaust, there occurred the first massive round up of German Jews known as *Kristallnacht,* or the Night of Broken Glass. Thirty thousand Jews were arrested, 267 synagogues were set aflame, and 7,500 shops were looted. Within weeks of the invasion of Poland on September 1, 1939, the Nazis began setting up the first ghettos. Once the ghettos had been established, every Jew in Nazi Europe was homeless, living in a ghetto, in a camp, or in hiding. The ghettos functioned not only as a gathering point for the Jews prior to being sent to the extermination camps but also as an instrument of extermination in themselves. The daily ration of food in the Warsaw Ghetto, for example, was about 220 calories, with 7 to 8 people occupying every room in the ghetto.

The mass killing operation began on June 22, 1941, when Germany invaded the countries of Eastern Europe, from the Baltic to the Black Sea. Four *Einsatzgruppen* (or killing units) followed the army as it advanced. Their assignment was to kill every Jew they could find. On January 20, 1942, Reinhard Heydrich, head of the Reich's *Sicherheitsdienst* (or Security Service), convened the Wannsee Conference on the outskirts of Berlin, where government officials worked out the logistics for the annihilation of European Jewry. On December 8, 1941, the first of six camps designed for the purpose of gassing and burning the Jews went into operation at Chelmno. By the end of March 1942, the Sobibor and Belzec extermination camps were operational, followed by Majdanek in April and Treblinka in June. The most infamous of the murder camps was Auschwitz-Birkenau, where the first transport of Jews marked for death arrived on February 15, 1942. Over the next three years, two-thirds of the Jews of Europe, including a million and a half children, were systematically exterminated.

Ramifications

The Nazis' effort to "purify" the world of the Jews was an effort to rid the world of a certain teaching symbolized by the very presence of the Jewish people. It is a teaching concerning the absolute sanctity of every human being, one that is fundamental to the testimony that the Jews bring to the world. And it is fundamentally at odds with Nazi thinking.

Targeting the Jewish soul and Judaism for complete annihilation, the Nazis set up a special section of the Gestapo, the secret police, called *Judenforschung ohne Juden* (Research into Jewish Matters without Jews). Their job was to learn everything they could about the Jews so that they could most effectively achieve their aim. In their extermination of the Jews, the Nazis set out to destroy the very notion of something holy, of something beyond both personal will and natural accident, that abides at the core of humanity. Assaulting the holy core of humanity, they used the Hebrew holy calendar to plan their attacks against the Jews. By degrees it became illegal to observe the

Sabbath, to study Torah, to pray, to put up a mezuzah, to use a ritual bath, to get married, to have children, to bury the dead, or to wear a beard. In the end, the Nazis reduced the death of a human being into a matter of indifference, and the human experience into a matter of expedience.

The Nazis achieved this end in various ways. They designated children and the elders—those who receive a people's memory and those who transmit it—as first targets. Because the crime of the Jew was existing in the world, the most heinous criminal was the one who brought the Jew into this world: the mother, through whom alone, according to Judaism, blessing comes into the world. Knowing the Jewish teaching that the soul is made of its name, the Nazis undertook an assault on the name. The tearing of the name from the soul took its first concrete form in 1938, when the Nazis added the name *Israel* to every Jewish male and the name *Sarah* to every Jewish female in Germany. In the camps, where a number took the place of the name, Jews were identified by this number in order to receive the meager food ration.

The result of the Nazis' systematic brutalization of the body and degradation of the soul of the Jew was a distinctively Nazi creation: the *Muselmann*. The Muselmann was a creature who should have been dead but was not. He did not speak, he did not eat, and he did not react to blows. Utterly isolated from the living, he fell outside the circle of death and the human experience. He was the denizen of the antiworld that the Nazis had created and to which they had relegated the Jews, empty of life, meaning, and value. He was the embodiment of the Nazi atrocity inflicted upon humanity called the Holocaust. The ultimate goal was to obliterate the very notion of the absolute sanctity of the human being that makes death and the human experience matter.

David Patterson

See also Disasters, Man-Made; Genocide; Hate Crimes and Death Threats; Jewish Beliefs and Traditions; Massacres

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HOMICIDE

Homicide is literally the death of one person at the hand of another. The term derives from the Latin: *homo* (human being) and *caedere* (to kill). Thus, in its purest sense, the term is free from implication of intent or criminality despite a persistent perception by some to the contrary. These latter views derive from the circumstances under which the life was taken. Manner of death is a shorthand means of classifying "why" a death occurred. There are four traditionally recognized specific categories of manner of death—natural, accident, suicide, and homicide; if a death cannot be conveniently placed into one of the foregoing, the manner of death is certified as "undetermined."

Medicolegal investigators charged with making the determination of manner of death are usually the coroner or medical examiner. The legal system has a vested interest establishing the guilt or innocence of a perpetrator in causing a death. In criminal cases, when the state prosecutor attempts to establish the perpetrator's criminal responsibility he or she must also consider the elements of the crime to properly classify the death: (a) unlawfully causing death, (b) of a living human being, and (c) the perpetrator's state of mind (mens rea). In the completely separate civil legal system, the plaintiff's counsel attempts to show actionable responsibility by the defendant for a death.

An interesting element in the all-important issue of *intent* in medicolegal death certification is that the medical examiner/coroner is not charged with determining the legal construct of intent, rather the inference of intent is made by the prosecutor and then presented to the grand jury; the ultimate determination is by the trial jury. Thus, a hunting "accident" in which an individual is inadvertently killed when mistaken for prey would be properly medicolegally classified as a homicide rather than an accident because the risk and potential outcome of the act were obvious. On occasion, some certifiers tend to follow malleable rules in such cases—perhaps out of misplaced concern over the stigma associated with the term homicide. Regardless, the shooter's intent is not the concern of said certifier.

Culpability of Action

In both legal and medicolegal definitions of homicide, the death may be caused by an act *or omission*. The end result is of import, not the means by which it is achieved. Thus, starving an infant to death (omission) is equivalent to shooting a victim in the head (act) as a homicide, in that, in both instances, the death was achieved as the result of the perpetrator's actions. Also, it is not necessary for the perpetrator to physically contact (either directly as in a beating or by extension as in a shooting) the victim. If a victim has severe natural disease, such as coronary artery disease, and a robber threatens the victim (brandishing a weapon and/or making threats), causing stress in the victim culminating in a fatal heart attack, the perpetrator is directly responsible for the death, which would correctly be designated as a homicide. The broad legal categorization of "homicide" does not require knowledge; however, criminality relates to motive/intent or disregard for others' safety as evidenced by the mens rea. In criminal cases, the perpetrator's state of mind speaks to intent; culpable mental states include intentional/purposeful, knowing, reckless, and negligent. The killer's *thoughts* (as established in court) become the fundamental basis for the legal categorization of the death. Equally important is the perpetrator's understanding of right and wrong and/or the actor's inability to adhere to the right at the time the act occurred, also known as "the insanity defense." The medical specialty of forensic psychiatry/psychology (also known as behavioral science) is devoted to ascertaining a subject's true state of understanding and intent. That there may not be agreement among the various experts speaks to the difficulty in getting to the fundamental truths in some cases. If significant interpretations of the same facts in different ways by specialists can and does occur, it should come as no surprise that lay juries can become hopelessly deadlocked in an individual case.

Systems of Social and Criminal Justice

Another important fact is the tiered justice system in operation—criminal and civil. Although not commonly considered important in homicide cases, the civil justice system may serve to right perceived wrongs in the criminal system. This is in no small part due to the different levels of certainty involved. Typically, criminal courts require scientific evidence "to a reasonable degree of certainty," while in civil litigation, the standard is "to a reasonable degree of probability." The civil standard is best understood as "more likely than not," while criminal courts use a much higher standard of proof. The net result is that a criminal jury may determine that "reasonable doubt" exists regarding the homicide of a victim, while a civil jury, examining essentially the same facts, but using the lower standard of proof, may determine that the perpetrator is responsible for the death of the victim. There is no double jeopardy in such situations because the criminal matter relates to the legal system, while the civil pertains to reparations for the wrong.

Types of Homicide

Jurisdictions vary in the number of legal categories devoted to the act of criminal homicide. These may include capital murder, murder (first or second degree), manslaughter (voluntary or involuntary), and negligent homicide. When the term "homicide" is used in legal categorization, it carries a requisite modifier—an often forgotten element when laity considers the act of "homicide" as inherently bad. Some cite the Old Testament biblical reference of the Ten Commandments dictum, "Thou shalt not kill." In fact, the original text states, "Thou shalt not murder." This extremely important concept may help explain why some view all killing of another person as bad. Equally

important, some jurors may bring such a philosophy to their deliberations—an obvious sticking point in considering potential capital punishment.

Murder is unlawful killing with the intent to kill and/or do serious bodily harm—that is, premeditated malice exists, either expressed or implied. Premeditation is another element, however, that can be formed essentially instantaneously, providing the assailant has formed intent and fully considered the killing. Capital murder occurs under certain limited sets of predefined circumstances, in which the nature of the crime is considered so abhorrent in the jurisdiction that the potential punishment includes state-sanctioned homicide of the perpetrator. Such cases often include the killing of an officer of the law and child abuse murder. In jurisdictions without capital punishment, such cases are treated as conventional murder cases.

Lesser levels of unlawful killing lose the "capital" designation. In murder cases, the qualifiers first or second degree are added, selecting out certain homicides as "worse" than others. In reality, despite the elements of the killing being the same, the major difference is in the potential sentence for the crime. The state, in the person of the prosecutor, considers the facts of the case and determines the appropriate criminal charge based on their understanding of the particulars.

The next lesser level of homicide is manslaughter—unlawful killing without premeditation or malice aforethought. Manslaughter may be voluntary, indicating that the assailant chose to perform the act but did so without forming the intent to kill or do serious bodily harm; examples include crimes in the heat of passion or unplanned homicide committed during commission of another crime, such as shooting an individual during the commission of a robbery. Involuntary manslaughter refers to deaths caused during commission of an unlawful act, such as a drunk driver causing the death of another in a motor vehicle collision. Deaths occurring during a medical procedure, such as surgery, do occur and are generally attributed to the condition precipitating the need for the procedure. For example, death during a cardiac catheterization for coronary artery disease is typically attributed to the latter and assigned a natural manner. Although rarely seen, cases of gross negligence and/or wanton disregard by a medical practitioner may be classed as manslaughter.

The least of the criminal homicides is criminally negligent homicide. In such deaths, the perpetrator demonstrates a disregard for a known and unjustifiable risk that the criminal action could result in serious injury or death, and this disregard must be such that a reasonable person in the same circumstances would not have disregarded the risk. There is no intent in these deaths. Examples would include causing death due to improper operation of a motor vehicle and (depending on case particulars) causing death due to medical neglect (as by bedsores resulting in infection) of an individual under one's care.

Ultimately, in criminal proceedings, the question is an assailant's culpability for the death. Two scenarios occur with some frequency where defense might argue that there is no intent and thus no legal responsibility by the charged. Both tend to be interrelated—multiple assailants and multiple wounds (also known as "overkill"). In the law, the hand of one is the hand of all; therefore, even if a suspect were to engage in what was believed to be a simple robbery but the victim ends up shot and dead, the nonshooting partner in crime is as responsible for the homicide as the one who actually pulled the trigger. The precise legal level of homicide charged may vary, depending on the facts of the case. Similarly, if one of a group of assailants were to merely cut the victim's arm while another stabbed the victim in the heart, both are fundamentally responsible for the death. In a medical sense, both the wounds are physiologically part of the mechanism of death, despite one being arguably less severe *in and of itself*, primarily because the wounds were not inflicted individually but in toto.

Depending upon the circumstances, the act of homicide may be considered justified (as in self-defense), necessary (as in execution by the state in capital punishment), or heroic (as in an act of war). The killing of a lawful combatant during wartime is a part of the process; however, the killing of noncombatants is considered a war crime. The overall determination of "right" and "wrong" in each of these instances serves as the basis for the legal categorization. Although religion does not directly enter into the legal determinations of what constitutes the act of homicide, it is interesting to consider that the three major monotheistic Abrahamic religions—Judaism, Christianity, and Islam—are all heavily influenced by the act of homicide, from the Judeo-Christian Old Testament

story of Cain and Abel to the accounts of Abraham and Isaac/Ishmael.

Certain religious proscriptions against suicide directly relate the stigma of homicide as suicide is the killing of oneself (self-homicide). Interestingly, the era of political correctness has skewed media accounts of terrorist acts by ignoring the suicide stigma with the vast majority focusing on the killer and terming such acts a "suicide bombing," rather than recognizing the usually far more numerous victims in a "homicide bombing."

Special Types of Homicide

A reflection of the fascination humans have with the taking of another's life is evident by the numerous special designations for various categories of homicide, for example, those relating to how the victim is connected to their killer including parricide (patricide or matricide)—killing one's parent (father or mother), fratricide/sororicide—killing one's sibling (brother or sister), and filicide—killing one's child. Additional types of homicide are specific for the type of victim, including infanticide/neonaticide—killing an infant/neonate, regicide—killing of the monarch, and genocide—extermination of an entire class. An increasingly common "special" class of homicide is the killing of a child by the caregiver, either a sitter or a parent. In such cases, defense often attempts to obfuscate the true elements of a case by arguing that an abused victim actually died from nonexistent natural disease or minor trauma, or in the case of homicidal suffocation, that the victim merely succumbed to a natural entity, such as SIDS (sudden infant death syndrome) or equivalent. A similar case can occur in elders and other debilitated/weak victims. "Gentle" homicides, such as asphyxial deaths, may leave precious little physical stigmata with which the medical examiner can work. The recognition of the criminal killing in all cases, especially these types of cases, relies on the investigation of the case, for without suspicion and documentation, it may prove easy for a perpetrator to kill a child and possibly even get away with it.

Mens Rea, or the Intentionality of Action

Society seeks to understand "why" a killing occurred. As such, it is not surprising that the legal basis for classification of killing relies to a large part on the killer's *intent*. In determining what, if any, criminality is associated with the taking of another's life, one must consider motive. The motive influences the demographics of any individual homicide. The perpetrator–victim relationship is important and can affect a jury's determination of responsibility. Even with many seemingly disparate sets of facts, most cases can be narrowed down to one of several basic motives (the classic seven deadly sins). Through the years, the precise meaning of the various terms has evolved, although the general concepts have remained intact. The seven deadly sins as described by Dante in *The Divine Comedy* include *luxuria* (extravagance or lust), *gula* (gluttony or self-indulgence), *avaritia* (greed), *acedia* (sloth), *ira* (wrath or anger), *invidia* (envy), and *superbia* (pride).

The relationship of the offender and the victim is one of the most important factors in understanding a killing and often ties directly to motive. One of the most common homicides involves one spouse causing the other's death. The reason commonly revolves around anger ("they had it coming"), lust ("sex," either too much, not enough, or with someone else), and/or greed (money or the like). Another increasingly common type of homicide is drug-related and/or gang-related killing, which occurs commonly for business purposes—either monetary/territorial greed or pride/revenge.

Life has become devalued, particularly by those seeking escape from poor socioeconomic conditions. An aggravating factor is that death has become glorified in popular culture via media, music, and movies—a "live fast, die young" mentality has bred a new type of perpetrator. Assailants are younger, as they are exposed to violent influences at ever-earlier ages. Additionally, societal dynamics have favored an increasingly mobile populace leading to weaker ties within and between communities with resultant lack of concerned citizen witnesses. As a direct result of myriad factors there has been an increase in stranger-on-stranger crime. Over the past several decades, the solve rate for homicides has decreased with concomitant lack of investigative leads based on victim–perpetrator interpersonal dynamics. Regardless, unprovoked stranger-on-stranger crime is arguably much more difficult to defend than one drug dealer killing another over a deal gone bad.

In certain cases, responsibility for the act of homicide is treated differently, either limiting the assailant's responsibility or expanding it to include other's actions and natural disease. In conventional medicolegal thought, the concept of time since the injury is irrelevant; the medical examiner/coroner considers only the relation of the eventual death to its initiating event (proximate cause). In such situations, a death that can be directly linked back to a prior assault by another individual at some point in time is attributed to the initiating event. For example, a gunshot wound severing the spinal cord, resulting in paralysis, would be considered the cause of pneumonia developing 5 years later from which the victim eventually died. The simple rule of thumb in such instances is the "but for" test—*but for* the original assault, would the victim have died at that specific point in time? In some legal circumstances, the "year and a day" rule applies. This is a legal holdover from English common law limiting legal responsibility for the causation of a death to 366 days after the initial (proximate) act. In such instances, despite causing the original injury—even if it clearly and directly eventuates in a later death— homicide is arbitrarily legally removed as the cause of death if the victim is (un)fortunate enough to live a year and a day past the assault. A related concept has to do with transferred intent. Should a victim survive an attack and make it to medical treatment, the attacker assumes the risks associated with the outcome of medical procedures. Medicine does not guarantee outcomes—even with the best treatment, an individual patient may not fare well for any of a number of reasons, some of which may be foreseen and others not. For example, a patient sustains a wound injuring the torso, requiring a medical imaging study with a contrast agent; the patient is exposed to a chemical to which they are allergic (despite no one knowing that the victim was allergic); and death results from an anaphylactic reaction to the contrast agent. In this scenario, despite the assailant not giving any medical care and despite no knowledge by any of the players that the victim was allergic to the agent, the attacker is ultimately responsible for the death because *but for* the original injury, there would not have been need for the procedure ending in death. In some cases, defense may argue that "the doctors killed the victim" and, at most, all the defendant did was injure the victim. If a victim requires medical treatment, the assailant vicariously assumes the outcome of it. Thus, the homicide may occur from an otherwise natural disease that the victim would not have had but for the original assault.

Finally, a recent trend also directly related to public interest has been the popularization of seemingly all things forensic. Television and movies have popularized the work conducted by forensic science practitioners, which has proved to be enduring entertainment. This two-edged sword of Damocles hangs over homicide investigators. On one hand, the popularization of forensics has meant that juries now better understand complicated principles, such as DNA technology and fingerprint identification. On the other hand, jurors have come to *expect* scientific evidence in all cases, even those where none exists. This latter, so-called *CSI effect* has proved challenging in presenting cases because homicide detectives, despite the scientific impossibility of proving a negative, have been challenged with the unenviable task of explaining why something does not exist.

J. C. Upshaw Downs

See also Causes of Death, Contemporary; Death-Related Crime; Familicide; Medical Examiner

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Honor Killings

Honor killings involve the murder of female family members, usually by brothers or fathers, in retaliation for allegations of premarital or

extramarital sex, for refusing an arranged marriage, or for attempting to obtain a divorce. Honor killings reflect crimes and violence against thousands of women every year all over the globe.

The practice is most frequently found in traditional, male-dominated societies primarily in communities in the Mediterranean Basin, the Middle East, the Indian subcontinent, and sub-Saharan Africa. Such killings take place when male family members feel their power or status in the family has been threatened and are condoned by the following reasoning. First, any sexual relationship of women outside of marriage is considered a shame and sullying of the woman's honor. Second, that honor is the property of the primary male family member and not of the woman herself. Third, women in the family bear immediate and full responsibility for preserving family honor, even against their will and, therefore, deserve the maximum physical penalty when family honor is not maintained.

The murder of females in the Middle East is an ancient tradition. Prior to the arrival of Islam in 622 C.E, Arabs occasionally buried infant daughters to avoid the possibility that they would later bring shame to the family. This practice continued through the centuries. It may still occur today among Bedouins, who consider girls most likely to sully the family honor. Currently, several thousand women a year are victims of honor killings carried out for a wide range of offenses: marital infidelity, refusing an arranged marriage, asking for a divorce, having premarital sex, flirting, wanting to go to college, or even having been raped. Unusual cases include the husband who murdered his wife based on a dream that she betrayed him; the Turkish father who slit his daughter's throat in the town square because a love ballad had been dedicated to her over the radio; or the 16-year-old mentally retarded girl who was raped in Pakistan and found guilty of dishonoring the tribe. Numerous murders are ruled an accident, suicide, or family dispute, if they are reported at all. Police and government officials are often bribed to ignore crimes and to hinder investigations. A woman beaten, burned, strangled, shot, or stabbed to death is often ruled a suicide, even when there are multiple wounds. Many women are buried in unmarked graves, as their existence is supposed to be removed from the community, even after death.

Patriarchy and Honor Codes

The problem of honor killings is not a problem of morality or of ensuring that women maintain their own personal virtue; rather, it is a problem of domination, power, and hatred of women who, in these instances, are viewed as nothing more than servants to the family, both physically and symbolically. Patriarchal systems privilege a male point of view. In such societies, actions that challenge men's sense of control and status will be punished. Honor killings are based on the assumption that women themselves are powerful and dangerous beings. All sexual institutions, such as polygamy, repudiation, and sexual segregation, can be viewed as strategies for containing such female power.

Honor killing is also frequently viewed as self-contradictory, because is it often justified, by its participants and supporters, as an attempt to uphold the morals of a religion, which at the same time generally forbids killing as morally wrong. Ironically, religious moral codes, such as those found in Islam, denounce such elevation of gender status by either men or women, rather emphasizing the equality of the two genders. Indeed, the Qur'an makes clear in chapters four and seven that men and women are not only equal in the eyes of God, but were created together and simultaneously from a single cell.

Collective Acceptance and Social Pressure

Women can support the honor killing of a family member, as most of them agree that the family is the property and asset of men and boys. Women often accept their fate and expect to be executed, even in the case of incest and rape. Such power of culture has conditioned both the victim and the killer to accept their roles. Confessions of honor killers repeatedly testify that their immediate social circle, family, clan, village, or others, expected them and encouraged them to commit the murder—from society's perspective refraining from killing the woman debases her relatives and shames the code of honor set by the community's standards, where the man is the guardian of his female relatives, and consequently, he is supposed to take any measures to satisfy community concerns.

For example, there was a case where an Egyptian father strangled his unmarried pregnant daughter

to death because he believed that other villagers judged him for his daughter's unmarried status. This father killed his daughter to end the shame and stigma he experienced from neighbors. In another incident, a 25-year-old Palestinian man who hanged his sister with a rope maintained that, "I did not kill her, but rather helped her to commit suicide and to carry out the death penalty she sentenced herself to. I did it to wash with her blood the family honor that was violated because of her and in response to the will of society that would not have any mercy on me if I didn't.…" The desire to end communal shame can cause families to go to extreme lengths. The al-Goul family, for example, spent six years searching for their daughter Basma who had fled after her husband accused her of infidelity. Despite her departure, contempt for her family kept spreading in the crowded Jordanian village where a women's chastity is everyone's business. Because of her alleged infidelity, villagers ostracized her parents, deemed her eight sisters unmarriageable, and taunted her five brothers on the street.

The prevailing view that devalues and belittles women is derived from sociocultural factors that are justified by a distorted and erroneous interpretation of religion, especially of Islam. Victims are killed by their fathers, husbands, brothers, cousins, or sons; and in communities where crime is persecuted, the younger the killer, the lesser the punishment. Women of the family (mothers, sisters, and relatives) often define the killing and even help set it up.

Legal Dimension of Honor Killings

Though honor killing crimes are widely known to be underreported, the UN Population Fund estimates that more than 5,000 women and girls are killed for reasons of honor each year. The majority of such killings take place in Pakistan, Jordan, and Turkey, according to UN reports. While on location in 2003, *National Geographic* documentarian Michael Davie estimated that at least three women were victims of honor killings each day in Pakistan. In some countries, the acts are considered legal. For example, state penal codes such as Article 340 of Jordan, Article 562 of Lebanon, Article 548 of Syria, Article 153 in Kuwait, Article 237 in Egypt, Article 309 in Iraq, Article 334 in the United Arab Emirate, Article 70 in Bahrain, Articles 418–424 in Morocco, and Article 252 in Oman provide exemptions from any punishment for all those who kill female family members who commit adultery, labeling male killers as acting in a "fit of fury" rather than committing a murder. In Saudi Arabia, the Sudan, Iran, Pakistan, and Qatar, sanctions under Shari'a law provide similar exemptions.

Honor Killings in the European Union

Increasingly, incidents of honor killings have begun to take place across Europe. According to the Swedish women's advocacy group Kvinnoforum, honor killings remain hidden from public view and are limited to immigrant populations. Such notions are echoed by Scotland Yard, which listed more than one hundred murder investigations as suspect honor killings in 2004, involving women from Turkish, Middle Eastern, and South Asian backgrounds. In 2005, German police agencies reported 47 honor killings of Muslim women across the country. In many cases, the reactionary idea of cultural relativism is used to justify women's victimization and to excuse Islam as a backward tradition within Europe. Thus, Europe's strong emphasis on cultural relativism within the mainstream media and intellectuals' attempts to explain such murders as part of the prevalent patterns of domestic violence against women in Western societies has led to a culture of tolerating intolerance.

Today with immigration and cultural exchange, basic changes occur not only in economic structures but in social relations as well, and these challenge the underlying principles of Islam as a social order. Immigration and world markets bring to Islam disintegration, upheaval, conflict, and contradiction, and the effect is felt mostly in home life and the structure of the family. Muslim women, especially in the European Union, live the conflict between traditions and the laws of emancipation in most European nations. The emergence of feminine initiatives and female self-determination challenges the central principle of the Muslim family, which emphasizes male supremacy and the systematic inhibition of females.

Honor Killings and Human Rights

The challenge to the central principle of the Muslim family from the emergence of feminine initiatives and female self-determination has

spurred a number of attempts to reverse legal sanctions of honor killings. In 1994, the UN's Commission on Human Rights appointed a special monitor of violence against women. UNICEF and the UN Development Fund for Women quickly followed suit. In 2003, Amnesty International launched a worldwide campaign to halt violence against women, linking honor killings to human rights. Cultural traditions change slowly, but these and other efforts to reduce violence against women and emphasize human rights in all cultures may eventually have positive outcomes.

Najwa Raouda

See also Death-Related Crime; Domestic Violence; Homicide; Legalities of Death

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Hospice, Contemporary

Hospice refers to a facility where terminally ill individuals and their significant others receive care. But hospice as a philosophy refers to care provided by an interdisciplinary team of professionals and trained volunteers to a terminally ill patient and their loved ones when the patient has a life expectancy of six months or less and the focus of care is on comfort, pain control (palliative care), and quality of life, rather than on curing the illness. The National Hospice and Palliative Care Organization estimated that 1.3 million patients received hospice care in 2006. According to the Hospice Foundation of America, there are more than 3,200 hospice programs in the United States, Puerto Rico, and Guam. Hospice programs are also common in Canada and Europe, with programs becoming more common in other parts of the world, particularly Africa, Asia, Latin America, the Caribbean, and the Middle East. This entry will describe the hospice philosophy of care, eligibility criteria, the relevance of advance directives, the components of hospice care, and legal/ethical issues related to hospice care.

Hospice Philosophy

Hospice philosophy is based on the idea that dying is a normal part of the life cycle, that opportunities for growth are possible when nearing the end of life, and that the quality of an individual's life is more important than the duration of one's life following the diagnosis of an illness for which there is no cure. Hospice views the patient and family as the unit of care and promotes patient self-determination, with patients and their families participating actively in the care planning process. Efforts to achieve a high quality of life stress the importance of physical, emotional, and spiritual comfort, the preservation of one's dignity while dying, and the ability to live one's final months and days in the least restrictive environment possible. Ideally, hospice care is provided in an individual's home, with friends and family providing care with the support of hospice professionals and trained volunteers. If this is not possible, hospice care may be provided in a specialized hospice facility, a hospital, or a skilled nursing facility. Hospice care has also been provided in hospice programs within prisons.

Components of Hospice Care

Holistic Care

The care plan for a hospice patient and his or her social support network provides holistic care, or care for the needs of the "whole person": physical, psychological/emotional, social, economic, and

spiritual. Physical care is palliative rather than curative, with an emphasis on comfort care and pain control while maintaining the highest degree of alertness possible. Psychological/emotional care focuses on meeting the basic psychological and emotional needs of the patient, assisting the patient and his or her support network in coping with the patient's impending death, and to facilitate communication about any unresolved issues that can be addressed. The hospice team will encourage and facilitate continued social interactions between the patient, his or her social support network, and the broader community until the time of the patient's death. Information about resources to diminish the economic stress that can result from the terminal illness of a family member is provided. Spiritual care assists the patient and family in finding meaning and purpose in the remainder of the patient's life, discussing beliefs about what happens after death, and assisting the survivors in coping with the death of the patient. Expressive therapies (e.g., drawing, painting, and writing) can be used with the patient as well as the family during the dying and bereavement processes. It is also becoming more common to use prescriptive music for the benefit of the patient and family by holding music vigils. Music thanatologists provide contemplative music played with harp and voice. Following the patient's death, bereavement follow-up services are provided for at least one year. These services range from telephone contact, cards and notes, individual and family counseling, online support services, grief support camps for children and teenagers, and public remembrance services.

Interdisciplinary Care Team

Hospice care is provided by a team of professionals that includes a physician/hospice medical director, a registered nurse, a social worker, and a chaplain or other counselor. Ancillary team members include a bereavement counselor, a home health aide/homemaker, a pharmacist, and volunteers who assist by providing emotional support, direct personal care, respite to the caregivers, doing light housekeeping, running errands, or working in the hospice office. Other professionals may be consulted, including medical specialists, dieticians, occupational and physical therapists, and complementary therapists (massage therapists, expressive therapists).

Eligibility and Payment for Hospice Care

In order to be eligible for hospice care, a physician must certify that the patient's life expectancy is six months or less if the illness runs its normal course and that the patient is choosing palliative care (comfort care) rather than curative care. Common diagnoses of hospice patients include but are not limited to those dealing with the end stages of AIDS, ALS (Lou Gehrig's disease), Alzheimer's disease, cancer, heart disease, kidney disease, liver disease, lung disease, multiple sclerosis (MS), and Parkinson's disease.

Hospice care is covered by most health insurance plans, HMOs, and managed care organizations. Medicare, a federally funded program available to individuals 65 years of age and older or to individuals with disabilities, also has a hospice benefit. To qualify for financial reimbursement, the hospice program providing care must meet the Medicare criteria for hospice care reimbursement. Individuals with limited financial resources who are uninsured or underinsured may be eligible for Medicaid, a joint federal-state program. Information about Medicaid-eligible hospice programs within a particular state is available from the state Medicaid office. Additional financial assistance for medical expenses may be available from local civic, religious, or charitable organizations.

Legal and Ethical Issues

According to the American Health Lawyer's Association, there are numerous legal issues that arise when an individual is facing a life-limiting illness. Estate planning should be done with the assistance of legal counsel, and families should be aware of legal issues relevant to the provision of end-of-life care. Many of the legal issues related to the provision of hospice involve requirements for the licensing of hospice programs and medical professionals, as well as compliance with regulations to qualify for third-party payment for hospice services. However, several legal issues relate directly to the rights of patients during the process of dealing with a terminal illness.

Due to the Patient Self-Determination Act, a federal law passed in 1990, patients receiving services from health care institutions that receive Medicare or Medicaid funding must be advised in

writing of their rights under existing state law to complete advance directives—oral and written directives describing a person's wishes regarding medical care—that are used in the event that a person cannot speak for himself or herself. Advance directives for hospice patients typically include a do not resuscitate (DNR) order. An individual can designate a trusted relative or friend to make decisions on his or her behalf (e.g., a health care proxy, durable power of attorney for health care, or medical power of attorney) or prepare written documents that record one's wishes under various circumstances (e.g., a living will). It is important to identify which type of advance directive is considered a legal document in one's state of residence.

Several other legislative efforts have advocated for the rights of the terminally ill. In 1989, the National Conference of Commissioners on Uniform State Laws drafted the Uniform Rights of the Terminally Ill Act, which has been passed by many individual states. This Act allows an individual to leave instructions for a physician to withhold or withdraw life-sustaining treatment in the event the individual has a terminal illness and is unable to participate in medical treatment decisions. Some states, such as Michigan and Oregon, have special state laws that relate to "death with dignity." The Michigan Dignified Death Act (MDDA) requires physicians to inform terminally ill patients about their right to choose hospice care. Patients with terminal illness have rights and choices under the MDDA. The law also gives immunity to physicians from civil and administrative penalties for prescribing controlled substances. The Oregon Death with Dignity Law, originally passed in 1994 and defended before the Supreme court in 2006, carries individual rights one step further, providing terminally ill patients with the right to request assistance in dying from a physician under specific legally defined criteria. "Physician-assisted suicide," which is only legal at the present time in the state of Oregon, is an extremely controversial legal and ethical issue. Many hospice advocates strongly believe that physician-assisted suicide would not typically be requested by a terminally ill individual who is receiving proper end-of-life care and therefore should not be a legal option for anyone. Although not a routinely used option, physicians may utilize palliative sedation (also known as terminal sedation) to relieve symptom distress of terminal restlessness and agitation during the last hours or days of a dying patient's life. The doses of these sedative drugs are titrated to maintain the patient's comfort without compromising respiration or hastening death.

A variety of ethical issues are equally relevant to hospice care. These issues are not laws, but principles that guide the work of health care professionals when assisting patients and their families with the provision of end-of-life care. These issues include communication with terminally ill patients, withholding and withdrawing treatments, the use of artificial nutrition and hydration, ethical issues related to research, and the issue of access to hospice care.

Sharing bad news with a patient and his or her family is never an easy task, and health care professionals must carefully balance the right of any patient to a full and honest explanation of his or her situation with factors such as issues of patient competence, a patient's right to decline information, and religious or cultural norms that influence how or to whom information about a diagnosis or prognosis is delivered. Concerns about diminishing hope must be weighed in relation to the potential harm that can be caused by withholding information or the loss of trust that may result when a patient learns the truth. Providing information about hospice care as an option in a timely manner is crucial because referrals in close proximity to the time of death prevent hospice care from being fully and effectively implemented. Time is required to achieve the maximum benefit of hospice care to the patient and family.

According to the International Association for Hospice and Palliative Care, the appropriateness of offering or withholding a particular treatment to a hospice patient is determined by balancing the possible benefits with the potential risks of the treatment, keeping in mind that therapy with no chance of benefit can never be justified. If a treatment will merely prolong the dying process without enhancing the patient's quality of life, it is probably best withheld. However, this decision is often a difficult and complex one that must be determined by the unique circumstances of the case that are carefully considered during discussions involving the hospice team, the patient, and the family.

Families are often distressed when a loved one stops eating and drinking because it is never

comfortable to imagine a loved one being thirsty or "starving to death." Decisions about interventions related to artificial nutrition and hydration should be based upon their ability to restore or enhance the quality of life in relation to the potential for negative side effects. In-depth discussion about the pros and cons of these interventions must occur, and unless quality of life can be restored or enhanced without the occurrence of detrimental consequences, these interventions should not be done.

Clinical trials—experimental research—may be open to participation by individuals with a terminal illness. If the goal of the clinical trial is to enhance quality of life rather than to seek a cure for the illness and the potential for harm is low, it would be appropriate for a hospice patient to participate. Health care professionals have an ethical responsibility to protect hospice patients from participating in studies that are not in their best interests, while allowing them the freedom to participate in research activities that may preserve their ability to contribute to society in meaningful ways.

Ideally, access to hospice care would be equal to all regardless of where people live, their race, religion, cultural beliefs, language, age, financial means, or their diagnosis. A 2003 Hastings Center Report on access to hospice care notes three specific areas where the most powerful barriers to access exist: (1) laws, policies, and regulations affecting the organization, financing, and delivery of hospice care; (2) attitudes and practices of health care providers, including referring physicians, who are the gatekeepers of the system; and (3) misunderstanding, misinformation, and stigma against hospice by consumers. Living in a largely death-denying society places many barriers in the way of timely referral to hospice care.

During times of concern about economic resources, it is reassuring that research has demonstrated the cost-saving benefits of hospice for Medicare and other insurance programs. However, economically disadvantaged individuals who lack health care coverage may not have access to professionals who can help them navigate the system to gain resources for end-of-life care. In addition, current policies regarding the hospice cap will need to be examined by federal policymakers and legislators. The National Alliance for Hospice Access is actively advocating for Congress to modify the aggregate hospice cap, which would ensure that patients receive care for as long as they are eligible and that hospice programs are able to survive financially.

The challenge of meeting the need for end-of-life care is anticipated to rise due to the projected demographic shift in the population of seniors in the United States to over 69 million by the year 2030. The pursuit of a "good death" by baby boomers who are aging during a time of increased awareness of the benefits of hospice care will place great demand on the ever-growing number of hospice programs. Gaining knowledge about this option for end-of-life care will facilitate an individual's ability to access these services in a timely fashion, making every day count when one's remaining days in this life are limited.

Carla Sofka

See also End-of-Life Decision Making; Hospice, History of; Living Wills and Advance Directives; Palliative Care

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Hospice, History of

Caring for the dying has been a human responsibility throughout recorded history. The word "hospice" comes from medieval institutions that offered practical and spiritual assistance to pilgrims on their way to the Holy Land. In the late 19th century, the Irish Sisters of Charity applied the term to those nearing the end of life's journey when they opened Our Lady's Hospice in Dublin, Ireland, and, later, St. Joseph's Hospice in London, England.

Subsequently, the word "hospice" has come to designate both a philosophy of care and programs specializing in end-of-life care. In this sense, hospice services are designed primarily to provide care for those who are dying or who have no reasonable hope of benefit from cure-oriented interventions, along with their family members.

Founding of the Modern Hospice Movement

Cicely Saunders (1918–2005) led the establishment of the modern hospice movement. After training as a nurse, a chronic back problem prevented her from functioning in that role. Saunders then retrained as a medical social worker and took a position in an oncology unit at St. Thomas's Hospital in London.

Meeting and eventually falling in love with an agnostic Polish Jew who had inoperable cancer helped Saunders crystallize some of her ideas. David Tasma was 40, separated from his family and country, in great physical pain, lonely, and dying after what he thought of as an unfulfilled life. Reflecting on his situation spurred Saunders to ask what she could do to relieve the suffering and meet the needs of others like him.

As her interests matured, Saunders volunteered at St. Luke's in Bayswater, a well-established home for the dying. Here, she noted that pain-killing drugs were given at regular intervals instead of waiting until the pain returned. Also, whenever possible, injections were avoided and drugs were given orally, a method that was easier for patients and for family members caring for patients at home. These basic principles later became fundamental in hospice care.

When Saunders shared her desire to work with dying patients with a physician friend, he told her there was much to learn about pain control and the way to do it was to study medicine because it was doctors who desert the dying. She soon began studies that led to her medical degree. After qualifying in April 1957, Saunders obtained a research scholarship in pain research at St. Mary's Hospital and began to implement her ideas at St. Joseph's Hospice, Hackney. Before long, she determined to organize a body of like-minded supporters, develop a plan for an independent hospice facility, raise money, purchase a site, and build the new facility.

St. Christopher's Hospice and Further Developments in England

St. Christopher's Hospice in southeast London opened in 1967 as a purpose-built, inpatient facility designed to implement the new goals of excellence in clinical practice, research, and education in care of the dying. Although a private charitable foundation independent of the National Health Service (NHS), St. Christopher's maintains good relations with the NHS and receives funding for patients transferred from NHS hospitals.

Like many early hospice programs, St. Christopher's primarily serves patients with far-advanced cancer, but has always accepted some individuals with motor neuron and other diseases. For everyone, care is addressed to whole person, including physical, psychological, social, and spiritual dimensions, and to their family members.

Subsequent developments of the hospice movement in England took many forms. They include additional free-standing, inpatient hospice facilities (often purpose built); other inpatient hospice facilities built with private money on the grounds of NHS hospitals and then operated by the NHS; palliative care or continuing care inpatient units within some NHS hospitals; hospice home care teams developed to support the work of general practitioners and district nurses; hospital support or consultation teams to advise on the care of the dying in acute care hospitals; and hospice day care programs.

Hospice Care Worldwide Outside England and North America

It is difficult to briefly summarize the situation of hospice care around the world. One estimate is that early in the 21st century, there are hospice and/or palliative care initiatives in 115 countries. Where these initiatives are most robust (e.g., North America and Western Europe), there are well-established hospice/palliative care programs and services, along with national, regional, and specialist professional organizations; widespread exchanges of information (e.g., through the Hospice Information Service at St. Christopher's, publication of books, articles, and journals, and conferences); and the creation of teaching posts in palliative medicine. Elsewhere, there are problems in establishing and funding services, integrating those services with mainstream health care in the local areas, establishment of necessary governmental policies, confronting professional and social attitudes (e.g., regarding fears of addiction), adequate availability of medications (e.g., opioids), workforce underdevelopment, and coping with unique problems (e.g., poverty in many countries and struggling with the scale of HIV/AIDS in areas like sub-Saharan Africa). For about 25 years, the World Health Organization has sought to foster hospice/palliative care, improve professional education in this field, remove legal sanctions against opioid importation and use, and disseminate core principles of pain management. Nevertheless, it still seems that where the need is greatest, resources are least available. Unrelieved suffering is common and the scale of the problems faced by dying people around the world is increasing.

Hospice Care in Canada

In Canada, palliative care services were first developed at St. Boniface General Hospital in Winnipeg and at the Royal Victoria Hospital in Montreal in 1974. These services typically included an inpatient unit that is based in a large acute care teaching hospital, a consultation service, a home care service, and a bereavement follow-up program. Subsequently, a broad variety of nearly 500 programs and services offering "hospice palliative care" have been developed across Canada, along with several provincial associations and the national Canadian Hospice Palliative Care Association (www.chpca.net).

Hospice Care in the United States

In the United States, hospice care began in September 1974 with a community-based home care program in New Haven, Connecticut. From this modest beginning, hospice care has spread across the country. In 2005, the National Hospice and Palliative Care Organization (www.nhpco.org) estimated there were 4,160 operational hospice programs in all 50 states, the District of Columbia, Puerto Rico, and Guam.

Hospice programs in the United States are organized in many ways. Most are independent, free-standing agencies; others are hospital based, divisions of home health agencies, or based in long-term care facilities. Approximately two-thirds of hospice programs in the United States are nonprofit in character; the remainder are for-profit or government organizations. Nearly one-fifth have their own inpatient facility.

In 2005, American hospice programs served over 1,200,000 patients. Approximately 800,000 of these individuals died while receiving hospice care—roughly one-third of all Americans who died that year. Over three-quarters of all hospice patients who died were able to die in a place they called home—a private residence, a nursing home, or other residential facility.

In the United States, hospice programs originally cared primarily for elderly cancer patients, but as the movement has developed, hospice principles have also been applied to care for people with AIDS, motor neuron diseases (e.g., amyotrophic lateral sclerosis, ALS or Lou Gehrig's disease), Alzheimer's disease, and other life-threatening

conditions such as end-stage heart, lung, or kidney disease.

American hospice programs provide bereavement care to an average of two family members per hospice patient. In addition, most American hospice programs provide bereavement services to their communities, with community members receiving nearly one quarter of all hospice bereavement services.

The Hospice Medicare Benefit

In 1982, hospice funding in the United States was approved as a Medicare benefit. Admissions criteria typically required a diagnosis of terminal illness, a prognosis of fewer than 6 months to live, and the presence of a primary caregiver in the home. Medicare reimbursement is organized in four basic categories of services: (1) regular, daily home care; (2) general inpatient care; (3) short-term respite care; and (4) continuous in-home care (providing the presence of a trained hospice staff member in specified blocks of time). Each category of services has a stipulated reimbursement rate, typically adjusted to take into account differential costs over time and in different geographical areas.

The Medicare hospice benefit pays for over 80% of hospice services (other hospice funding sources include private health insurance, Medicaid, and charitable donations). The benefit emphasizes home care and shifts reimbursement from a retrospective, fee-for-service basis to a prospective, flat-rate basis. Thus, a hospice program receives the amount specified in the rate category for each day in which a dying person is enrolled in its care, regardless of the services it actually provides to that person on any given day.

All monies provided under the Medicare hospice benefit (except those paid to an attending primary physician) go directly to the hospice program, which is responsible for designing and implementing individual plans of care. No service is reimbursed unless it is included in the plan of care approved by the interdisciplinary hospice team. That gives the hospice program an incentive to hold down costs and only to provide care relevant to the needs of an individual patient and family unit.

The Medicare hospice benefit, which is now a model for other forms of reimbursement for U.S. hospice services, is a desirable option for individuals who qualify. The benefit is available in all Medicare-certified U.S. hospice programs (nearly 94%). It is broader than other Medicare benefits and is intended to cover all costs of the care provided. Although the benefit does incorporate upper limits on reimbursement to a hospice program, these are expressed in terms of program averages and total benefit days for which the program will be reimbursed, not in figures that apply to any particular individual. Once a person has been accepted into a Medicare-certified hospice program and while continuing to qualify for services, the law prohibits involuntary discharge. Hospice care is also covered by Medicaid in 43 states and the District of Columbia, as well as by 82% of managed care plans and most private insurance plans.

Hospice Care for Children

Programs of hospice and palliative care for children, adolescents, and their family members have taken many forms since the early 1980s. In England, Helen House, an eight-bed facility with four family apartments built on the grounds of a convent in Oxford, began serving children with life-shortening conditions and their families in November 1982, offering a "home away from home" for respite and end-of-life care. In February 2004, Douglas House, a seven-bed facility on the grounds of Helen House, became the world's first "respice" for people 16 to 40 years of age.

Earlier in the United States, in the mid-1970s, Dr. Ida Martinson, a nursing faculty member at the University of Minnesota, developed a home care program for dying children using volunteer nurses in Minnesota and parts of Wisconsin. This program demonstrated that many seriously ill children want to be at home with their families, even when their illness is far advanced; these children can be cared for appropriately in the home setting; and many family members, including parents, siblings, and other relatives, can benefit from being involved in care when guided and supported by knowledgeable professionals.

Canuck Place Children's Hospice in Vancouver, Canada, and George Mark Children's House in San Leandro, California, were the first inpatient facilities to offer hospice care for ill and dying children in North America. Both Canuck Place (since November 1995) and George Mark Children's

House (since April 2004) offer respite care, transitional care between home and hospital, and end-of-life care specially designed for children with progressive, life-limiting conditions.

Children's hospice services have also been sponsored by other community and institutional sources, as well as by some adult hospice programs in the United States, such as Daniel's Care at Hospice of the Bluegrass in Lexington, Kentucky, and the Child and Family Program at Hospice of the Florida Suncoast in Pinellas County, Florida. In addition, some institutions have developed specialized prenatal hospice programs (offering support and care to parents and siblings when a fetus has died in the womb) and neonatal hospice programs that employ hospice and family-centered principles of care for infants born with incurable conditions that are incompatible with life or for infants who die suddenly and unexpectedly in a neonatal intensive care unit (NICU).

Hospice Care and Palliative Care

Hospice care is a form of end-of-life care designed to minimize sources of pain and distress, improve quality of life, and offer opportunities for growth. Both the hospice movement and its philosophical principles have helped stimulate other forms of specialist palliative care, such as consultative services in academic medical centers and other hospitals in the United States that focus on relief of distressing symptoms and on the primary role of the physician. These programs represent efforts to manage pain and other distressing symptoms with or without reference to their origin or their relationship to dying and death.

Charles A. Corr

See also Caregiving; Hospice, Contemporary; Palliative Care; Terminal Care

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Humor and Fear of Death

It is useful to divide a discussion of humor and the fear of death into three sections—humor where certain death is imminent, humor where there is a high risk of death due to circumstances or occupation, and humor and the everyday fear of death that lurks somewhere at the back of each individual's mind, even when safe and healthy.

Humor in the Face of Imminent Death

Anthologists are fond of quoting humorous "last words" by someone whose illness is known to be fatal or who is about to be executed. Such humor may be seen as a display of courage and indifference, possibly one that a particular society expects, encourages, and admires, at a time when the fear of death is reinforced by its immediacy—or as simply whimsical by its inappropriateness.

King Charles II of England said to his courtiers when dying in 1685: "I am sorry, gentlemen for being such a time a-dying."

Voltaire, when asked on his deathbed to forswear Satan, said: "This is no time to make new enemies."

It is an even more marked phenomenon when professional humorists die. When Edward Gwenn, the English actor, was dying in 1959, someone said, "It must be hard." He replied, "It is but not as hard as farce."

Lytton Strachey, dying in 1932, said: "If this is dying, I don't think much of it."

Witty men manage witty endings, but the electric chair induces bad puns. They are funny mainly because of the circumstances, of the forced cheerfulness at a fearful time. Perhaps it is a bid for a cramped immortality in the reference books.

George Appel, about to be executed in the electric chair in New York in 1928, said: "You're about to see a baked appel."

James French, when about to be executed in the electric chair in Oklahoma in 1966, said: "How about this for a headline for tomorrow's papers? French fries!"

Mocking Others' Fear of Death

There is an even nastier side to this, the mocking humor that has been employed by others of the visible fear exhibited by an individual facing death, particularly if they belonged to another race or religion defined as "other." Sometimes it relates to a real event, sometimes it is just a joke. It may be tasteless, but it is a genuine form of humor and was experienced as such by those using it and receiving it, which is the only test. Humor is not necessarily good humored.

According to author Sebag Montefiore, at a dinner to celebrate the foundation of the *Cheka* (Soviet secret police) held just a few weeks after Grigory Zinoviev had been executed, Karl Pauker, Stalin's court jester, acted the scene of Zinoviev's pleadings and death. There was great merriment and much applause. Pauker was dragged back into the room by two others pretending to be guards. He mimicked Zinoviev's terrified cries of "For God's sake call Stalin." Pauker, who was a Jew himself, imitated Zinoviev raising his arms to the heavens and crying, "Hear oh Israel the Lord is our God, the Lord is one." Stalin enjoyed it so much that Pauker did it again. Stalin laughed so much he felt sick and gestured at Pauker to stop.

Fear of death may also take the form of jokes or humorous narratives about those whose fear of death has led them into cowardice or disorder in the face of danger. Mockery of the excessive fear displayed by others facing death is not only a facet of popular culture, but has been skillfully used by noted playwrights as diverse as William Shakespeare and Peter Schaffer and novelists such as Charles Dickens, Anatole France, and Jaroslav Hašek.

Humor in the Face of Danger of Death

A common form of humor associated with those whose tasks regularly expose them to the risk of death is a morbid one that makes light of death and its fears. It is well seen in the songs composed and sung by British soldiers in World War I when a million of them died, fighting in the trenches.

(Tune: Salvation Army hymn)
If you want the old Battalion
We know where they are
We know where they are.
They're hanging on the old barbed wire.
We've seen them.
We've seen them.
Hanging on the old barbed wire
The bells of hell go ting-a-ling-a-ling.
For you but not for me. . . .
O death, where is thy sting-a-ling-a-ling.
O grave thy victor-ee.
The bells of hell go ting-a-ling-a-ling.…

The tradition continued in World War II, notably in the Royal Air Force (RAF), a branch of service with a high casualty rate. These are songs about the death of comrades and friends, a death that may well be experienced by the singers tomorrow, something of which they were well aware. We do not know who composed them. Indeed they are a collective product certainly sung together, probably put together piecemeal. It is worth noting that they parody religious and sacred themes in a profane way. There are humorous songs, too, about death in other dangerous occupations, such as fishermen working out at sea. Singing them together may help group morale and solidarity in the face of a high risk of death.

It should also be kept in mind that in English-speaking countries there is a social expectation that humor will be used in the face of danger. Memoirs recall the joke that broke the tension, for it is seen as important enough to be recollected and preserved. It is seen as culturally appropriate and, in time, becomes part of an established tradition that, in turn, induces similar behavior. Sometimes the humor is given far greater importance and frequency in retrospect than it had in practice, partly because humor is pleasantly memorable and partly because such memories feed our self-respect and the respect of others.

There are also good studies of how humor is used in the face of danger and death to ensure reliability and cooperation under circumstances where an individual's giving way to an understandable fear or indeed to recklessness would endanger the lives of others. We can see this in accounts of the use of jokes and comic insults in the inducing groups, such as ironworkers or astronauts, to manage their fears and act as a coherent team in the face of danger.

Popular Humor and Distant Death Known Only From the Mass Media

During the last half of the 20th century, a new form of popular humor developed about fearful events resulting in death These were the waves of joke cycles about disasters, such as the loss of the American space shuttles Challenger and Columbia, the sinking of the British ferry Herald of Free Enterprise, the crashing of the Concorde in Paris, and the fatal fire on the oil rig Piper Alpha. There were also jokes about the sudden death of celebrities, from John F. Kennedy to that of his son John-John and from Mrs. Gandhi to Princess Diana. The jokes reflect the realities of modern societies in which sudden early death before the life cycle has been completed is rare and yet when it happens, it is the subject of intense attention by the broadcasters. They compete to provide pictures of disasters, and their reporters try to instill into their viewers and listeners the sense of fear of the sight of death they believe they ought to be conveyed. But viewers are sitting at home in comfort and safety while the anguished messages are sandwiched between trivial advertisements and quiz shows, which creates a great deal of incongruity and hence laughter.

What's the favorite drink at NASA?
Seven-Up with a splash.

Why did Mrs. Indira Gandhi change her deodorant?
Because her right guard was killing her.

What did the mortuary attendant sing as he packed Diana and her boyfriend into body bags?
Zippedy-Dodi, Zippedy-Di.

Such humor is not callous nor is it a form of coping, for the joke tellers have no direct experiences to respond to and overcome. Rather, it is mocking a fear of the face of death experienced by media professionals who are now trying to sell it to the public. It is quite different from the humor that accompanied an Irish or Newfoundland wake or Mexico's Day of the Dead. This is the humor of societies where death is more familiar. The form that humor takes in the face of the fear of death depends on the degree to which a society denies and hides death or accepts and embraces it. Even in the latter case, it is difficult to know the extent to which the humor of death is related to the fear of death rather than to grieve past deaths or the way the individual's death temporarily disrupts the social order. It is customary, indeed compulsory, to speak of death in a quiet, respectful, and solemn way. Humor is nearly always a transgression, even at times an inversion of social rules that demand certain attitudes and ways of speaking, and the case of death and the fear it inspires is one more instance of this.

A possible source of modern fears of death and their humor is the media-induced sense of foreboding about general risks due to modern technology, such as nuclear power stations, genetically modified crops, or new chemicals, even though these have generated very few deaths indeed. Sociologists have even spoken of the "risk society," the *Risikogesellschaft,* in which such fears are central to social and political life. Whether anyone other than a few activists is troubled in any immediate way by these fears may be doubted. Yet in the one case where there was a real risk, real precautions, and a real popular fear of death, there was again humor: This was the Chernobyl disaster when a socialist-built and operated nuclear power station spewed radioactivity into the atmosphere. In socialist Hungary, a country close to the Ukraine and Chernobyl and at that time a satellite of the Soviet Union, they joked:

What's the new shopping craze?
To save money, people are buying Kiev bread instead of fluorescent light bulbs.

What did the workers celebrate at the May Day parade in Budapest?
The radiant friendship between Hungary and the Soviet Union.

How was the May Day Parade in Kiev organized?

In rows. In the front row were the party activists, in the second were all the youth communist activists, in the third all the union activists, and finally all the radio activists.

Types of Fear of Death and Humor

The fear of death may be a fear of one's own death, fear of the death of a close relationship, or even simply fear of the sight of death. It may be a fear of the pain of dying or a fear of what happens after death. The former is less often a subject of humor (pain as such rarely is) and perhaps even less so in a society where the alleviation of pain through drugs, even to the point of inducing unconsciousness or accelerating death, has become usual. Rather, for unbelievers it is the fear of personal annihilation and for believers it is the fear of a bad reincarnation or the fear of the torments of hell or purgatory that are linked to humor. There are many forms of humor related to many different facets of the fear of death.

Christie Davies

See also Death, Sociological Perspectives; Death Anxiety; Depictions of Death in Television and the Movies; War Deaths

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IMMORTALITY

Humankind's mortality and death generate reflections on immortality as a solution to the problem of death. In the following text, immortality will be analyzed in different types, the problem of immortality and personal identity/personhood will be explored, and arguments surrounding the value of immortality will be presented.

Types of Immortality

The immortality of humankind can be distinguished in two different types: (1) mundane immortality, where humans continue to exist forever without dying in the earthly world, and (2) transmundane immortality, where humans continue to exist forever in the earthly or transcendent world after dying. Transmundane immortality can be distinguished in personal, transpersonal, and impersonal immortality. Personal immortality implies that the person who existed before death continues to exist in some form after death. Transpersonal immortality implies that the person existing before death is transformed into another person after death. Impersonal immortality implies that the person existing before death is transformed into an impersonal existence after death that still in some relevant sense has a connection with the earthly person. This distinction is important to the question of the value of immortality and why immortal existence would be of comfort in the face of death, if indeed it is. It can be argued that if the problem with death is that *I* as a person dies, immortality would be a comfort to me to the extent *I* continue to exist in some relevant sense. However, what it is for *me* to exist in a relevant sense is open to a number of different interpretations.

Besides the different religious ideas around transpersonal or impersonal immortality, in terms of the migration of the soul into other people or creatures or by becoming part of the all-inclusive universe, we also find secular ideas about personal immortality that would not imply the continued existence of *me* in the normal sense. One concept related to Einstein's idea of time as a fourth dimension claims that we are immortal because every time segment of *me* continues to exist, forever, in the time dimension of our existence, and when we live our life we move consecutively through these different time segments. Hence, when I die, what continues to exist, forever or as long as time exists, is the former time segments of *me*.

Transmundane Personal Immortality

Within the perspective of a transmundane immortality, we find three basic types of personal immortal existence:

1. Humans continue to exist as nonbodily souls after death.
2. Humans' nonbodily souls continue to exist in new bodies after death.
3. Humans continue to exist as new unities of souls and bodies, where the soul is not a distinct entity separated from the body.

Transmundane personal immortality should confront two philosophical problems: the problem of personhood (i.e., what makes a human into a person) and the problem of personal identity (i.e., what makes a person at one time the same person at another time). When relating personhood or personal identity to only an earthly existence, death is seen as a radical change to a human's life that has to be dealt with.

Personhood and Personal Identity

Connecting personhood to a nonbodily soul that is unaffected by death and continues to exist after death will deal with both the problem of personhood and personal identity. This, however, presupposes a dualism or separation in humans between the soul and the body, giving rise to new philosophical problems. First, it has been questioned how a nonbodily soul could interact with a physical body. Second, important aspects of personhood, (i.e., how we experience the world and ourselves) seem intimately linked to us having a body to interact with the world through, and that our bodies are part of our personhood. Continued existence as a nonbodily person would then be either unimaginable or so radically different from our bodily existence that it would be difficult to claim we are the same person, which is a problem for personal identity.

Human's nonbodily soul continuing to exist in a new body would solve the problem of personhood to the extent it is a new physical body. If it were a different body (for example a nonphysical body), the problem of personhood would remain because it is difficult to imagine how such a body would give us access to the world. Keeping the nonbodily soul after death would only partly solve the problem of personal identity because the soul is only one aspect of the personhood in the combination of soul and body. It can be argued that receiving a radically new body (whether physical or not) will imply that the person before and after death is not identical. Moreover, the problem of interaction between soul and body will remain. The idea of humans continuing to exist as a new unity of body and soul after death would solve the problem of interaction but, on the other hand, emphasizes the problem of personal identity because it is a *new* unity of body and soul.

Mundane Personal Immortality

Mundane immortality implies that humans cannot die (necessary immortality). However, mundane immortality could also imply that humans can die, but, as a matter of fact, do not die (contingent immortality). Both of these interpretations should be distinguished from radical life extension, which the advances in biomedical research have raised as a real possibility, where human life is prolonged but we will be prone to death and will die eventually.

Necessary immortality would radically change the features of human existence in many ways, not only in the sense that human existence is prolonged into eternity. The fact that we are mortal and will eventually die and that we think of ourselves as mortal is taken to be intimately related to what it is to live as a human being. The vulnerability that makes us mortal will enable us to experience human emotions like suffering, which, in turn, is a precondition for empathy toward other people. If we were immortal, part of this vulnerability would have to be lacking, something that would change both our individual lives and social interaction with other humans. Likewise, it is argued that human beings arrange their life and have an attitude toward life that incorporates this knowledge that life is limited. This reflects how we relate to our human projects and also to essential features of human life, such as generational change.

Contingent immortality would solve the first problem of human vulnerability. However, it would still change the features of human life if life was not actually limited in time. Moreover, if we can die and still live forever, we need to live in an environment in which we do not encounter any risks that would jeopardize our lives. That is, in the world we presently live in, we will statistically die because we will eventually encounter one of the risks that will make us die. Such an environment would in itself be a radical change for human existence. A life extension would not imply such a radical change of human existence. This idea rests on the assumption that human aging could be slowed and the major deadly diseases could be cured, thus increasing the life span of humans. Even so, humans living in a world similar to the one we inhabit, and being vulnerable to death, would eventually die.

Problems of Mundane Immortality and Radical Life-Extension

The question of whether we have reason to pursue extended life, even into immortality, is related to the question of whether death is bad or not. If death is bad, as far as it robs us of future worthwhile life, extended life would be good until we arrive at the point where future life is no longer worth living. There is no principled reason why this would arrive when we presently die, and some have argued that this could give us reason to pursue continued life into eternity. A classical argument raised against this position is that if human life is extended far into the future, humans would eventually arrive at a point where life would become irrevocably tedious. That is, to preserve personal identity, the amount of change humans could go through is restricted. In order to avoid tediousness, humans would have to move through a series of different persons, not implying that a definite person is immortal. Here it is implied that such tediousness means that life is not worth living and humans would then be better off dead.

Several attempts have been made to counter this argument, focusing on different underlying assumptions. It can be argued that while humans' existence is more plastic and less static than assumed by the argument and with eternal existence, humans could find an infinite number of alternatives that could be explored and thereby avoid boredom. In regard to personal identity, it can be argued that we need not be identical at every point in time; it is enough that there is a continuity between the *me* at different consecutive times. In the same way we do not demand that we are identical when we are 20 years old and 80 years old, it is enough that we are relevantly identical today and tomorrow. It can also be argued that the memory of humankind is too restricted to encompass an eternal life, and hence would be forgetfully ignorant of the repetitious life we live. Likewise, the argument rests on a restricted view on what gives life meaning or value, focusing only on the subjective component. If life can have value regardless of how we feel about that life, even immortal life could be worth living. Moreover, even if true immortal life would result in meaningless life, perhaps life could be radically extended before this happens.

Now, even if immortality or radical life extension would benefit the individual person, it could constitute problems for society as a whole. These problems are of three different but related types:

1. Problems with overpopulation if people's lives would be prolonged and new people are born
2. Problems with creativity and development of society if older generations would not be replaced by newer generations
3. Problems with social justice if immortality would only be open to the few

A way to solve the problem of overpopulation would be to block the possibility to have children for people who are immortal. Of course, this could lead to problems of creativity and renewal. If trying to solve both of these problems by only allowing a few people to become immortal, then we face the problem of social justice.

In the end, the quest for immortality to avoid that *I* die, would seem to face us with philosophical problems implying that immortality in the real sense cannot be achieved without a radical change of who *I* am; a change that would not comfort *me* in the face of death. The more realistic quest for radical life extension is to confront the moral problems that will outweigh the benefits of prolonged life.

Lars Sandman

See also Death, Humanistic Perspectives; Death in the Future; Eschatology; Eschatology in Major Religious Traditions; Heaven; Life Support Systems and Life-Extending Technologies; Reincarnation

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INFANTICIDE

Infanticide is the killing of an infant, a child under the age of one year. Although the perception of infanticide holds some cultural variation throughout the world, the English Infanticide Act (1938) is clear; infanticide is defined as the killing of a child within 12 months of birth by the mother of the child.

This perspective of English law is also found in the legislation of some of the states of Australia, such as New South Wales, Western Australia, Tasmania, and Victoria. In Canada, under the Criminal Code of Canada, Part VIII: Offences Against the Person and Reputation Section 233, "A female person commits infanticide when she causes the death of her newly born child." In Asian countries, infanticide is not always the result of action by the mother. Rather, the decision for the killing may well be communal, such as a decision of the village, extended family, or the husband. Very few Asian countries, such as China, have clearly stated legislation prohibiting infanticide and even those that do, such as India, have practical difficulties implementing the law. The United States has no specific infanticide legislation; rather, the killing of children is dealt within the wider context of homicide law. Offending mothers face potential execution, although in most instances convicted mothers are granted suspended sentences.

Many cultural and religious factors contribute to the practice of infanticide, and much has been written about the practice of infant killing within a cross-cultural context. Although the belief persists that some cultures, such as the Chinese, are more accepting of infanticide, it is much more likely that such perceptual differences and tolerant practice toward infanticide are attributed to the prevailing stressors of the time, including those due to traditional cultural mores, religious orientation, sexual inequality, economics, and differing or changing standards of individual rights. With improved education and a modern worldview, the modern Chinese are just as abhorrent of infanticide as any other culture. In the following discussion the reasons for infanticide are presented within a historical context and within the changing contemporary experience.

Infanticide in Historical Context

The practice of killing children can be traced to prehistoric times and religious literature, including the Bible, which provides many examples of infanticide. In ancient Babylonian and Chaldean civilizations, abnormal infants were thought to be the offspring of witches and animals and were left to die by the road. In what is perhaps the earliest practice of eugenics recorded, during the dominant period of the Greeks and Romans, and particularly among the Spartans, deformed or weak infants were readily killed. In the Biblical story, the child Moses may have been abandoned in the river as an act of attempted infanticide. Indeed the abandonment of Romulus and Remus at the fabled origin of Rome may also have been attempted infanticide. In ancient China, folklore describes the deadly struggles among the Emperor's concubines for his favor. Such struggles often were intricate conspiracies involving court officials and eunuchs plotting to kill the Emperor's offspring in an effort to manipulate the succession to the throne. Other stories tell of the kidnapping and killing of young infants in a quest for the elixir of immortality.

History reveals periods where child killing appears to be related to "religious" practice. Such sacrifices were offered to appease angry gods in exchange for a good harvest or in gratitude for victory in armed conflict. The Aztecs offered children in sacrifice to the Rain God Tlaloc. The Incas sacrificed the young in return for fertility. East African tribes sacrificed their firstborn for a bountiful harvest. The Bible, in 2 Kings 6:28, tells of the King of Israel agreeing to boil his son to provide food to relieve a famine resulting from a siege in Samaria by the King of Syria. This act is in many ways intertwined with the

notion that children are the property of their "household head," as found in the Roman doctrine of patria potestas. Taken to its extreme, a child's right to life lies in the hands of the household head, and in many ancient societies this paternal right is absolute. This paternal right is manifested in the decree of the king or emperor, the local chieftain, the village elder, the clan's elder, and, of course, the biological father. Even in modern times, this notion continues to dominate in some Asian and African communities where the child is expected to fulfill the wishes of their parents. In China, the ancient concept of "filial piety" proposed by Confucius embraces this concept, and children are expected to bow to the wishes of their parents. This Chinese version of patria potestas extends to modern times, where neighbors stand by watching a child be beaten to death by his or her parent for some perceived wrong the child committed.

With the development of the large urban communities and industrial economies, children and women ironically became even more dependent on the male provider and protector, and the practice of infanticide increased in the early phases of industrialization.

Over time and with the rise of Christianity and industrialization, a social climate emerged that caused unwed mothers to face both religious and social sanctions. The "Enlightenment" had not improved the plight of the unwed mother, but had added an extra layer of sanctions. **Unwanted newborns** were disposed of regularly. Abandonment, overlaying, and drowning became common methods used to kill infants. Overlaying is a situation where the young child dies of suffocation by the clothing and body of its mother while sharing the same bed. Such events were often reported as "accidents and tragic," but were suspected to be intentional suffocation by many doctors. Eventually the Catholic Church reacted, becoming the first institution to institute penalties by calling overlaying a sin. States reacted with the introduction of stiff penalties, and ideas relating to child advocacy spread; neighbors intervened thereby saving infants and children from death.

Legislating Against Infanticide

Early legislation introduced to punish infanticide was harsh; women found guilty of killing their newborn were often put to death. Sacking, a form of execution, was particularly barbaric. In sacking, the woman was placed into a sack that was tied and thrown into a river or sea. This practice spread everywhere and is frequently re-enacted in Chinese films and television dramas, although it appears to be used more as a punishment for adultery.

Russia was the first country to adopt a more humane attitude toward the problem of unwed mothers and infanticide. By 1888, all European countries except England had made legal distinctions between murder and infanticide by making infanticide punishable with more lenient penalties. Finally, in 1922 and later in 1938, England passed the Infanticide Act, which remains to this day. The 1938 law was improved and was the first time that the age of the child was extended to 12 months, which was an improvement on the 1922 act, which merely stated the "newborn." The introduction of the English law was perhaps a result of the frustration of the legal authorities of the day. Because of the frequency of unwed motherhood and the strong social taboos of the time, the reasons for the killing of an illegitimate child were not lost on the juries of the day. Frequently, juries refused to convict the mother despite the evidence of such an act of killing. Juries formed a view that the postnatal woman could not have formed the legally required mens rea (criminal intent). The authorities in England realized that the existing homicide laws were out of synch with the lay public, as it made no distinction between such "tragic" deaths and the other "heinous" crime of intentional killing. In a sense, infanticide legislation was a product of societal sympathy for women who were deemed to have been exploited and then abandoned by the child's father.

Another reason for the empathetic approach taken by juries was the nature of the evidence. In the 19th century, medical and forensic knowledge was in its infancy. The determination of live birth was by way of the "flotation test" method, which involved the removal of a lung or lung tissue from the dead infant and dropping this into a jar of water. If the tissue floated, it was deemed that the infant was born alive because there is air in the lungs that allowed the lung to remain afloat. This test was subsequently totally discredited but was nevertheless employed, and the results used as

evidence upon which countless numbers of mothers were sentenced to death.

Actus Reus and Mens Rea

The actus reus (guilty act) of killing of a child is clear and rarely a source of confusion. It is in the mens rea of the offender, namely the mother of the child, where many variations can be found. The English Infanticide Act (1938) provides the basis for discussion of the mens rea concept. The central premise of this piece of legislation is that " . . . the mind of the woman (mother), at the time of the act of killing, was imbalanced due to the effects of not having fully recovered from birth or by reason of the effects of lactation." In effect, the law provides a case for the offender (the mother) by deeming her to be mentally unsound and, therefore, incapable of forming criminal intent to kill. Thus, the perpetrator cannot be prosecuted to the fullest rigor of the law on homicide. In effect, the law on infanticide effectively limits the legal charge to manslaughter as opposed to murder. Furthermore, this legislation removes the need for the courts to deliberate the presence or absence of the mother's intent by presuming that she was mentally incapable of forming intent to kill. Supporters of the Infanticide Act argue that this is a sympathetic and humane piece of legislation that shows empathy for the many social and cultural taboos that may affect women, particularly those faced with an unwanted pregnancy. Opponents state that this legislation represents a death sentence for children who had the misfortune of being unwanted.

In modern society it is difficult to understand why a mother would kill her child; it is easier to conclude that she must be suffering from some kind of mental illness. The remedy for such an act is often the rendering of psychiatric care and rehabilitation. In contrast, fathers (or anyone other than the mother) involved with killing an infant will be charged with murder, with severe punishments if convicted.

In practice, the police, public prosecutors, and social workers effectively employ any evidence to support the assumption that the mother must have been mentally affected. One example is shaken baby syndrome, where a young baby is killed or suffers severe neurological damage as a result of violent shaking by an adult. One explanation for this act is attributed to the chronic stress and fatigue associated with child care, leading the caregiver to lose control and, during a period of intense frustration possibly triggered by incessant cries of the infant, violently shake the baby. Where this involves the mother, those sympathetic to her argue that the reason was her immaturity, emotional instability, and lack of support for a young, inexperienced mother. Others less sympathetic argue that it is a blatant act of violence intended to cause death or serious injury to a defenseless child.

Even in modern times, the crime of infanticide carries a certain amount of empathy if not social sympathy. Men thought to be irresponsible lovers are blamed for placing the vulnerable woman in such a desperate predicament. This applies equally in matrimony, where the husband may be blamed of his inadequate financial support and absent emotional assistance to his wife and children, such inadequacies being accepted as a "probable" cause of the mother's poor mental well-being, rendering her incapable of caring for her own child or killing her own child. When a dead child is found, an inquest is often held, but no formal charges, not even infanticide, are laid. The authorities prefer to use any possible suggestive evidence to label the child as a stillbirth.

Female Infanticide

A recent report by the United Nations highlights the epidemic of female infanticide. This epidemic is particularly prevalent in countries such as India, China, and Korea, but is found in many of the other Asian countries as well. In these countries, infanticide is a part of the cultural heritage of the past, in which a strong traditional view of male dominance continues to hold sway. Infanticide also is thought to be a product of a rapid improvement in economic status. The cultural ethos is that males are rightful heirs of not only family fortune, but also of the family's name. Females are looked upon as a burden upon the family's resources, as she will eventually be married and will then be expected to carry the name of her husband.

Many of the historically identified reasons for infanticides still prevail in the contemporary experience. In rural areas, where many of the people live in poverty, the "unwanted" female addition to

the family is resolved by killing the child. Scarce resources are saved for a male child. In countries such as China, where strict population control is exercised, the often stated "one child policy" (which began in 1979 and remains today) means that, for many families, the limited opportunity to have a child should not be "wasted" on a girl. The female child is deemed incapable of carrying on the family name and also not allowed to inherit the family land, for example. Hence, it is believed that many female newborns continue to be abandoned or killed shortly after birth.

Technology also indirectly plays a role in female infanticide. Given the nature of modern medical technologies, acts of female infanticides may be decreasing, but only because of options such as the early abortion of the female fetus. In urban India, for example, even without strict population control policies like those in China, the knowledge that the unborn fetus is female triggers anticipation and anxieties of required large dowries accompanying the marriage of a daughter, leading to the aborting of the female fetus or the killing of the newborn female if an abortion had not succeeded before the birth of the female child.

But nature has an innate way of dealing with the excesses of the human species. Female infanticide cannot be sustained or the human race will die. As it is, economists, politicians, and national leaders are beginning to highlight the potential biological and social consequences that sex selection, preference for a male child, and the subsequent imbalanced sex ratio that the strong desire for a male child can create. Indeed, this imbalance is already being witnessed in large Asian urban areas with a concomitant rise in deviant behaviors.

With education and an increased awareness of human rights and sexual equality, there is hope that infanticide will decrease in the future. Some evidence is available to support this contention and can be found in the increasing numbers of families that chose to have only one child regardless of the sex of the child. Other evidence points to existing monarchies around the world that appear willing to facilitate changes in ancient cultural rules and mores to allow for a female heir to continue the royal line.

Philip Beh

See also Abortion; Angel Makers; Causes of Death, Contemporary; Causes of Death, Historical Perspectives; Homicide; Infanticide

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Infant Mortality

Infant mortality is a subset measure of the construct morbidity, which itself is an estimation of the healthiness of a society. Characterized by variables that help to explain significant differences in infant death rates and incidence, part of the understanding of infant mortality is the construct of the death rate in a given population. As infant deaths under the age of 1 year has become relatively rare in societies that place major emphasis on maternal health, the infant death event assumes greater importance. The variables relating to infant mortality are discussed within the context of the general U.S. mortality rate.

Demographically the term *infant* refers to the child that is born alive and lives until he or she reaches the age of 1 year; that is, from birth through the 364th day of life. Some analysis also splits this time frame into the first 27 days (the neonatal period) and the last 337 days (the postneonatal period). Summative data for infant mortality based on the neonate and postneonate time frame

indicates that while the mortality rate has decreased since 1995 in both categories, mortality rates for neonates in 2004 and 2005 were 4.52 and 4.54 respectively per 1,000 live births compared to 4.9 in 1995. This rate means that 67% of all infant deaths occur during the neonate period. The leading cause of neonatal death is birth defects. Similarly, the rates for the postneonatal period decreased from 2.6 per 100 live births to 2.3 in 2004. The leading cause of postneonatal death is sudden infant death syndrome (SIDS). This last rate, 2.3, has been basically flat for several years.

Effect of Additional Live Births

When the Centers for Disease Control and Prevention (CDC) released the infant mortality data for the year 2002, it was noteworthy that for the first time since 1958, the mortality rate for infants had increased from 6.8 per 1,000 live births to 7.0. Subsequent analysis concluded that the major reason was an increase in the birth of very small or low-weight infants. Low weight at birth has been, and remains, one of the top three causes of infant mortality, and despite considerable progress being made in the care of very small infants, this condition remains a major predictor of infant death. The CDC indicates that the majority of babies born weighing less than 750 grams (1 pound, 10.5 ounces) will die before the end of the first year of life.

Infant Mortality Rates Over Time

Comprehensive data on infant mortality rates in the United States since 1915 are available. Cumulative analysis indicates that infant mortality has reduced by 93% since that time, while neonatal mortality has declined by 89%, and postneonatal mortality declined by 96%. The overall infant mortality rate in the United States for 2005 was 6.86. Based on data provided by the CDC, the infant mortality rates for the previous 10-year period are: 2004 (6.8); 2003 (6.9); 2002 (7.0); 2001 (6.9); 2000 (6.9); 1999 (7.1); 1998 (7.2); 1997 (7.2); 1996 (7.3); and 1995 (7.5).

However, there are significant differences observed between various racial, ethnic, and maternal age groups in the United States. Although these differences have always been significant, in more recent years the gap between black versus white infant mortality rates has widened. For the years 2002 to 2004, the data indicate the following infant mortality rates: black 13.5 per 1,000 live births; Native American 8.6 per 1,000 live births; white 5.7 per 1,000 live births; Hispanic 5.6 per 1,000 live births; and Asian American 4.8 per 1,000 live births. The racial/ethnic differences are still apparent when the age of the infant is considered. Neonatal mortality rates for black babies is 250% higher than for white or Hispanic babies, and postneonatal mortality rates for black babies are also 250% higher than white or Hispanic babies.

Further data indicate that women under the age of 20, or over 40, who give birth have the highest risk of losing their child during the baby's first year: under age 20, 10.1 per 1,000 live births; ages 20 to 29, 6.8 per 1,000 live births; ages 30 to 39, 5.8 per 1,000 live births; and age 40 and older, 8.6 per 1,000 live births.

Major Causes of Infant Mortality in the United States

Accounting for 68% of all infant deaths in 2005, the 10 leading causes of infant mortality in the United States were as follows:

1. Birth defects (congenital malformations and chromosomal abnormalities)
2. Low birth weight (disorders related to short gestation and low birth weight)
3. SIDS
4. Newborn affected by maternal complications of pregnancy
5. Newborn affected by complications of placenta, cord, and membranes
6. Accidents (unintentional injuries)
7. Respiratory Distress Syndrome (RDS) of newborn
8. Bacterial sepsis of newborn
9. Neonatal hemorrhage
10. Necrotizing enterocolitis of newborn

Over the last 25 years there has been little change in the top three causes of infant mortality, whereas the other top causes have frequently changed places. The mortality rate for birth

defects has decreased by 17% since 1996, which reflects major research efforts to treat defects, especially surgically, and to prevent them with education paradigms. Conversely, the death rate due to low birth weight has increased over the same period by 12%. The third highest cause of infant mortality, SIDS, has declined by 30% since 1996. The most likely reason for this change in mortality is based on the changed practice of positioning sleeping babies on their back. The rate for the fourth major cause, maternal complications of pregnancy, increased by 33% since 1996.

Impact of Public Health Measures on Infant Mortality

Research estimates that in 1900 the U.S. infant mortality rate was approximately 180 per 1,000 live births. Half a century later, the rate was 40 per 1,000 live births, after the use of antibiotics to treat many infectious diseases further reduced infant deaths. By the mid-1980s, the infant mortality rate was 10 per 1,000 live births. This dramatic change is associated with public health measures, notably water quality improvements including chlorination processes; the widespread use of vaccinations for polio, smallpox, and rubella; and sewage sanitation, the pasteurization of milk, and well baby clinics.

Infant mortality data offers an opportunity to consider the quality of life and general prosperity of a nation. The U.S. health care system spends more per capita than any other country, but it is not among the countries with the lowest rates of infant mortality. That distinction is given to a number of other nations, shown in Table 1 (pp. 602–603). Based on a 2007–2008 Human Development Report, these comparative data for the 1970 and 2005 period offer some important insights into the infant mortality phenomenon. One such insight is that, in general, infant mortality has significantly decreased throughout the world, or more specifically in those countries for which data are available. In some instances, such as the Scandinavian countries, Belgium, Japan, France, Spain, Italy, Greece, Korea, the Czech Republic, the United Arab Emirates, and Chile, for example, the decrease from 1970 to 2005 has been quite dramatic. These recent infant mortality rates show that a number of nations have lower infant mortality rates than the United States. These countries appear to share one important and common characteristic, universal/national health care systems that ensure the adequacy of prenatal care for all pregnant women, regardless of their ability to pay.

Access to Health Care

During the 20th century, major progress was achieved in the United States in reducing infant mortality, during both the neonatal and postneonatal periods. In spite of this achievement, the women of the United States still find their babies at higher risk than at least 20 other nations. Research conducted by the March of Dimes foundation indicates that nearly 4% of mothers receive no prenatal care and almost 11% of American mothers received inadequate prenatal care.

John E. King

See also Causes of Death, Contemporary; Childhood, Children, and Death; Demographic Transition Model; Quality of Life; Sudden Infant Death Syndrome (SIDS)

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Table 1 Infant Mortality Rate per 1,000 Live Births

Rank	*Country*	*1970*	*2005*	*Rank*	*Country*	*1970*	*2005*
1	Iceland	13	2	46	Uruguay	48	14
2	Norway	13	3	47	Croatia	34	6
3	Australia	17	5	48	Costa Rica	62	11
4	Canada	19	5	49	Bahamas	38	13
5	Ireland	20	5	50	Seychelles	46	12
6	Sweden	11	3	51	Cuba	34	6
7	Switzerland	15	4	52	Mexico	79	22
8	Japan	14	3	53	Bulgaria	28	12
9	Netherlands	13	4	54	Saint Kitts and Nevis	…	18
10	France	18	4	55	Tonga	40	20
11	Finland	13	3	56	Libyan Arab Jamahiriya	105	18
12	United States	20	6	57	Antigua and Barbuda	…	11
13	Spain	27	4	58	Oman	126	10
14	Denmark	14	4	59	Trinidad and Tobago	49	17
15	Austria	26	4	60	Romania	46	16
16	United Kingdom	18	5	61	Saudi Arabia	118	21
17	Belgium	21	4	62	Panama	46	19
18	Luxembourg	19	4	63	Malaysia	46	10
19	New Zealand	17	5	64	Belarus	31	10
20	Italy	30	4	65	Mauritius	64	13
21	Hong Kong, China (SAR)	…	…	66	Bosnia and Herzegovina	60	13
22	Germany	22	4	67	Russian Federation	29	14
23	Israel	24	5	68	Albania	78	16
24	Greece	38	4	69	Macedonia (TFYR)	85	15
25	Singapore	22	3	70	Brazil	95	31
26	Korea (Republic of)	43	5	71	Dominica	…	13
27	Slovenia	25	3	72	Saint Lucia	…	12
28	Cyprus	29	4	73	Kazakhstan	…	63
29	Portugal	53	4	74	Venezuela (Bolivarian Republic of)	48	18
30	Brunei Darussalam	58	8				
31	Barbados	40	11	75	Colombia	68	17
32	Czech Republic	21	3	76	Ukraine	22	13
33	Kuwait	49	9	77	Samoa	73	24
34	Malta	25	5	78	Thailand	74	18
35	Qatar	45	18	79	Dominican Republic	91	26
36	Hungary	36	7	80	Belize	…	15
37	Poland	32	6	81	China	85	23
38	Argentina	59	15	82	Grenada	…	17
39	United Arab Emirates	63	8	83	Armenia	…	26
40	Chile	78	8	84	Turkey	150	26
41	Bahrain	55	9	85	Suriname	…	30
42	Slovakia	25	7	86	Jordan	77	22
43	Lithuania	23	7	87	Peru	119	23
44	Estonia	21	6	88	Lebanon	45	27
45	Latvia	21	9	89	Ecuador	87	22

Rank	*Country*	*1970*	*2005*
90	Philippines	56	25
91	Tunisia	135	20
92	Fiji	50	16
93	Saint Vincent and the Grenadines	…	17
94	Iran (Islamic Republic of)	122	31
95	Paraguay	58	20
96	Georgia	…	41
97	Guyana	…	47
98	Azerbaijan	…	74
99	Sri Lanka	65	12
100	Maldives	157	33
101	Jamaica	49	17
102	Cape Verde	…	26
103	El Salvador	111	23
104	Algeria	143	34
105	Viet Nam	55	16
106	Occupied Palestinian Territories	…	21
107	Indonesia	104	28
108	Syrian Arab Republic	90	14
109	Turkmenistan	…	81
110	Nicaragua	113	30
111	Moldova	53	14
112	Egypt	157	28
113	Uzbekistan	83	57
114	Mongolia	…	39
115	Honduras	116	31
116	Kyrgyzstan	104	58
117	Bolivia	147	52
118	Guatemala	115	32
119	Gabon	…	60
120	Vanuatu	107	31
121	South Africa	…	55
122	Tajikistan	108	59
123	Sao Tome and Principe	…	75
124	Botswana	99	87
125	Namibia	85	46
126	Morocco	119	36
127	Equatorial Guinea	…	123
128	India	127	56
129	Solomon Islands	70	24
130	Lao People's Democratic Republic	145	62
131	Cambodia	…	98
132	Myanmar	122	75
133	Bhutan	156	65
134	Comoros	159	53
135	Ghana	111	68
136	Pakistan	120	79
137	Mauritania	151	78
138	Lesotho	140	102
139	Congo	100	81
140	Bangladesh	145	54
141	Swaziland	132	110
142	Nepal	165	56
143	Madagascar	109	74
144	Cameroon	127	87
145	Papua New Guinea	110	55
146	Haiti	148	84
147	Sudan	104	62
148	Kenya	96	79
149	Djibouti	…	88
150	Timor-Leste	…	52
151	Zimbabwe	86	81
152	Togo	128	78
153	Yemen	202	76
154	Uganda	100	79
155	Gambia	180	97
156	Senegal	164	77
157	Eritrea	143	50
158	Nigeria	140	100
159	Tanzania (United Republic of)	129	76
160	Guinea	197	98
161	Rwanda	124	118
162	Angola	180	154
163	Benin	149	89
164	Malawi	204	79
165	Zambia	109	102
166	Côte d'Ivoire	158	118
167	Burundi	138	114
168	Congo (Democratic Republic of the)	148	129
169	Ethiopia	160	109
170	Chad	154	124
171	Central African Republic	145	115
172	Mozambique	168	100
173	Mali	225	120
174	Niger	197	150
175	Guinea-Bissau	…	124
176	Burkina Faso	166	96
177	Sierra Leone	206	165

Source: State of the world's children 2007, by United Nations Children's Fund (UNICEF), 2006, New York: Author.

Informed Consent

Medical intervention and research trials often involve risk, and this risk can be substantial enough to include the death of the participant as one possibility. Even trials with medicines that are thought to have little potential for adverse consequences can lead to unexpected death because of the complex differences among people who are treated or who participate in clinical trials. This vulnerability is one of the more important reasons for the process of informed consent to be carried out with care, and improved through experience. Informed consent refers to an individual's act of acquiescing in an intervention or in research affecting the individual, without coercion and with full understanding of what is entailed by the intervention or research. The fundamental basis of the concept of informed consent is respect for people and respect for their autonomy—their right to self-determination. This concept has been particularly important in bioethics in the 20th and 21st centuries, and it undergirds the maxim that decisions about what is best for a person ought to be made by the one whose life is going to be affected.

The most important reason for the prominence of this concept in recent ethical thought is historical experience in which informed consent was not observed, and in which moral atrocities occurred. These historical events offer an important perspective from which to view the evolution of contemporary notions of informed consent. For example, the Nuremberg Code, which has provided a starting point for understanding the meaning and importance of informed consent, grew out of the trial of German physicians who conducted human experiments in Nazi concentration camps. All subsequent codes and systems of regulation related to informed consent derive in various ways from this code. The issue of informed consent was addressed and refined in several important subsequent documents, such as the Declaration of Helsinki adopted by the World Medical Association as a governing set of research ethics principles. This set of principles established the priority of human subjects' interest over those of science and society.

The U.S. Congress became increasingly concerned about informed consent during the early 1970s in part because of another historical event—the Tuskegee Syphilis Study. This involved poor black men who were not informed participants in the study and who were used as means to gain knowledge about the natural history of untreated syphilis. Though they were told about the fact that they had "bad blood," they were not told of the penicillin treatment effective against syphilis, a treatment that had become the standard treatment for the disease by 1947. As a result of the details of the Tuskegee study, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was formed. This led to the production of the Belmont Report in 1979, a report that built upon the principles expressed in the Nuremberg Code. This report embraces three principles that are now familiar and accepted as crucial for research involving human subjects, and which are vital to a robust notion of informed consent: respect for people, beneficence, and justice. For the purposes of understanding informed consent, the principle of respect for people is dominant and comprises two concepts: Individuals are to be treated as autonomous agents, and those individuals with less autonomy are entitled to protection. The latter concept is especially relevant in interventions and research involving children, though it is somewhat fluid in its definition because the autonomy of pediatric patients increases as they approach adulthood.

The statement in the Nuremberg Code that "the voluntary consent of human subjects is absolutely essential" has been interpreted as a legal capacity, a power of free choice based on knowledge and comprehension. But consent, which was once seen as a single event, has come to be understood as more of a process. The dominant theoretical framework for morally valid informed consent requires that four criteria be met: disclosure, understanding, voluntariness, and competence. Briefly, the information that must be disclosed includes (a) facts (such as risks, benefits and alternatives) that patients and providers believe relevant to the decision, (b) the recommendation of the professional, and (c) the purpose, nature, and limitations of consent. Understanding goes beyond disclosure because, while the elements disclosed can be objectively stated, true understanding involves many variables and it is more difficult to

assess. Establishing and documenting understanding remains a great challenge because information that has been disclosed but not understood contributes little to the ideal paradigm of informed consent. Voluntariness is another complex notion susceptible to misinterpretation, which means at a minimum that a decision has been made without constraints of coercion or manipulation. Finally, competence, which is conventionally understood as the ability to perform a task, has also become a complex concept whose definitions derive from law, psychiatry, and philosophy. The basis for a person's competence to make a particular decision relates to that person's ability to understand and think about the available choices and to use that understanding to make a decision.

Conceiving of informed consent in terms of the four elements of disclosure, understanding, voluntariness, and competence is useful when considering adults, but informed consent in pediatrics is complicated by the fact that three parties are involved (parent, child, and clinician/investigator) and the fact that the subject of research or treatment is the child. In pediatrics, autonomy does not take precedence. Instead the governing concepts are in "best interest of the child" and "avoidance of harm." The best interest notion is clearer in a purely clinical setting than in a research setting, where interventions are generally designed to contribute to general knowledge. Despite the difficulty of approximating truly informed consent in the setting of pediatrics and especially pediatric research, the obligation to advance pediatric medicine lends urgency to efforts to offer the closest possible approximation to informed consent out of respect for children as people.

In pediatrics, informed consent is better thought of as a combination of parental permission and, where appropriate, the more complex concept of the assent of the child. Many adolescents and some younger children possess the elements of competence. This is especially true perhaps of those who are exposed to long-term clinical trials and to the environment of a children's hospital for long periods of time. Younger children may not be developmentally capable of comprehending complex treatment regiments, but they do have some level of understanding that increases with age and experience. The notion of "assent," which complements the notion of "consent," must take into account these dynamic elements. Together, consent, permission giving, and assent constitute a set of rich ideas directed at preserving human dignity in the midst of vulnerability.

Raymond Barfield

See also Assisted Suicide; Childhood, Children, and Death; End-of-Life Decision Making; Euthanasia

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INHERITANCE

Assets accumulated over the life course that remain at death constitute a bulk estate, and the receipt of such a bulk estate is usually defined as an inheritance. Bulk estates are a major mechanism by which wealth is transferred. Because the distribution of wealth itself is highly skewed, so are bequests from estates. The greater the household wealth, the higher the likelihood of having received a bequest. At death, most individuals have little or nothing to bequeath beyond personal belongings and items of sentimental value. More broadly defined, inheritance is more than the transfer of bulk estates; it also refers to the total impact of initial social class placement at birth on future life outcomes. Inter vivos transfers or gifts are resources that are distributed among the living, typically from parents to children. Children of privileged classes are commonly the beneficiaries of a continuous flow of economic transfers that less privileged parents are unable to provide. These transfers are more important for a larger

proportion of the population than the transfers of bulk estates. Socioeconomic position substantially affects quality of life, and disparities in both are often transferred to future generations.

Patterns of inheritance are complex, and vary among societies as well as within a society. Inheritance patterns also vary with lineage systems and residence rules. Some inheritances are accidental; many are intentional. One important form of inheritance is the intergenerational transfer of bulk estates, the specific numbers and sizes of which are unknown. However, it is known that both the distribution and value of bequests are highly skewed, thus contributing to differential future life outcomes and economic advantages. In the following sections these issues are addressed.

Inheritance as the Intergenerational Transfer of Bulk Estates

The rules of inheritance have changed as other larger social, economic, and political structures have changed. What is transferred, to whom, how, and the amounts transferred have also varied historically.

Evolution of Inheritance From Hunter-Gatherers to the Present

Hunter-gatherer societies produced little or no surplus, and equal access to the simple productive technology and the environment resulted in egalitarian subsistence production. Because the accumulation of goods and property was difficult and not necessary, there was nothing to bequeath. With simple technologies that produced nothing to inherit, social stratification in the modern sense was largely absent in such societies.

Horticultural and Agrarian Societies

The first consequential form of inheritance occurred with the emergence of private property and the small-scale cultivation of gardens in horticultural societies. Despite intensive cultivation, small garden plots and simple tools limited food production but did permit small surpluses that were extracted from the less powerful producers by the more powerful, who claimed ownership of the land. This expropriation of surplus both reflected and resulted in increases in economic and political power, which were transmitted along kinship lines through mechanisms of inheritance. From these first systems of inheritance of status and power sprung an early form of social stratification.

With the advent of plows and the more complex technology for cultivation characteristic of agrarian societies, a larger food surplus was possible. Because children were considered economic assets due to their crucial roles in production, birth rates were relatively high. Landowner bequest of property was a significant mechanism for intergenerational transmission of privilege in agrarian societies. Property was typically passed to children of the deceased male, and his surviving wife received a maintenance income for the remainder of her life. Small family farms and businesses were often left to the eldest son, which lessened the problem of dissipating assets by spreading them too thinly among the usually large number of children. By keeping substantial inheritances in the hands of a few, social class inequality was reinforced.

Industrial and Post-Industrial Societies

The Industrial Revolution introduced technology that increased the quantity and rate of production. More efficient modes of production led to greater surplus production and, hence, the potential for greater accumulations over the lives of the producers. This brought more formal rules and practices governing the transfer of inherited properties and goods, and bequests were commonly written in wills and testaments. These rules were more complex than those of less advanced societies, and reflected an evolution of inheritance patterns that mirrored larger societal changes. Further, because the new modes of production involved an increasing use of machinery and less reliance on labor-intensive forms of production, the Industrial Age saw a distinct decline in the number of family farms. Fewer farms and small businesses remained to be inherited, so inheritances came to consist of money and other fungible goods produced by the liquidation of the decedent's property.

As modes of production changed, there were concomitant changes in what was inherited as well as in who was to inherit. Bequests came to be distributed among multiple heirs, but the equal dispersion of funds was easier because money is easier

to divide equally than farms or other forms of business property. Inheritances were also distributed to fewer offspring, which reflected the decline in birth rates compared to preindustrial societies. Other less fungible transfers, such as education, became a means through which opportunity and advantage were passed between generations. Educational institutions make admission decisions based on both merit and nonmerit attributes, and those who came to possess educational credentials, by whatever means, also came to have occupational and income advantages.

The advanced mode of production of modern industrial and postindustrial societies has led to vast surpluses and substantial economic inequalities. Although there is more for the privileged to inherit, social stratification has become less rigid.

Timing and Recipients of Inheritance

The timing of inheritance has also changed with societal evolution. Given the greater life spans found in industrial societies compared to those in less developed societies, individuals may live well into their 80s or 90s, with their children already middle aged before their parents die. The longer life cycle has meant a longer time from birth until receipt of inheritance. This, along with attempts to evade the taxation of bequests, has led to an increase in inter vivos transfers.

In industrial and postindustrial societies, by the time an individual dies, heirs are usually already established in their own careers, so an inheritance may not play the same role in the recipient's life as it would have in earlier societies. Given this, some individuals make bequests to their grandchildren, who might benefit more substantially than their adult children. Such generation-skipping trusts have become commonplace and typically occur when the deceased are confident that their own children are financially secure.

Other changes in family structure have complicated patterns of inheritance. As divorce rates rose in industrial societies during the 1960s and up to the early 1980s, the structure of the family changed. Different family structures led to more complex patterns of inheritance, as individuals divided estates among birth family members and stepfamily members.

Taxation of Inheritance

Inheriting an estate means accumulating assets other than wages and salaries. While vast wealth disparity is well documented in industrial society, there is a lack of systematic and comparable data on wealth transfers. In many societies, including the United States, only a very small proportion of estates are taxed. Estate taxes are essentially excise taxes on the privilege of transferring property upon death. The rate varies among societies but, typically, the larger the decedent's estate, the greater the tax liability. In addition to estate taxes, societies can have inheritance taxes, which are taxes levied on the privilege of receiving property from the deceased. Such taxes can vary considerably by state, as well as by the amount of property transferred, and the relationship of the heir to the decedent.

Typically, only very large estates are taxed; thus there is no systematic or complete accounting of the transfer of wealth across generations. Data for the United States indicate that wealthy parents pass on about half of the advantages associated with their wealth to their children.

Inheritance as Inter Vivos Transfers

Inheritance remains an important basis of intergenerational inequality because inheritance is more than the intergenerational transfer of bulk estates. Inheritance also refers to the total impact of initial social class placement at birth on future life outcomes. Children of privileged classes are commonly the beneficiaries of substantial and continuous flows of economic transfers. Parents seek to advance the futures of their children for a variety of reasons that include securing their own futures in the event that they become unable to take care of themselves or realizing vicarious prestige through the success of their children. With increasing overall life expectancy, grandparents have also become more actively involved in advancing the futures of grandchildren, both through inter vivos transfers and the provision of estates (including the use of generation-skipping trusts), thereby extending the potential for the transmission of privilege across multiple generations.

Advantages of Inheritance

There are several cumulative, nonmerit advantages of inheritance. Even minor initial advantages can

accumulate over the life course, reinforcing or extending existing inequalities across generations. These advantages are passed between generations in varying degrees.

The first of these advantages is that children inherit a standard of living and a quality of life from their parents. This includes basic necessities such as food, clothing, and shelter, but also extends to perquisites, amenities, and other sources of material well-being beyond subsistence. For the most privileged, this form of economic inheritance includes entertainment of various forms, toys, travel, vacations, enrichment camps, and private lessons, for example.

Second, from their parents children inherit cultural capital, or the knowledge and information needed to function as a member in good standing in society. This knowledge includes the ways of life of a group: lifestyles, consumption patterns, norms, values, beliefs, customs, and traditions. It includes, but is not limited to, etiquette, patterns of speech, demeanor, and comportment that are required for acceptance in higher social circles. This is a powerful but subtle means of transmitting social standards and social standing from one generation to the next.

The third of these advantages is that children inherit social capital from their parents. Social capital refers to social connections, and these networks provide access to power, information, and other resources. Children initially inherit a network of social relations from their parents. These connections can be important mechanisms of formal and informal social placement and advancement.

Fourth, the advantages of inheritance can be transmitted through inter vivos transfers. The parental infusion of capital to children can provide substantial advantages at critical junctures in the life course, such as going to college, getting married, buying a first home, and starting a business. These transfers are often substantial, and evidence suggests they are of equal or greater value than lump sum bequests.

These transfers are called transformative assets because of their capacity to lift a family beyond its own ability to generate assets. With the rise of corporations and the concomitant decline of family farms and businesses, inheritance increasingly takes on more fungible or liquid forms. Increasingly, a primary form of inter vivos transfer is payment for higher education, which in turn has the capacity to increase an individual's prospects for subsequent social mobility. In essence, these transfers represent parental investments in their children's future and future life chances.

Fifth, the advantages of inheritance may take the form of parental rescue or insulation from downward mobility. If society operated on strictly merit principles, then individuals who exhibit little merit would become downwardly mobile; however, parents often provide financial and other forms of support and intervention that prevent this. Adult children may seek parental assistance because of illness or injury, unemployment, divorce, or other setbacks. Parents may also provide intervention for adult children's personal problems in the form of legal assistance, counseling, or substance abuse rehabilitation. The full extent of these various forms of parental rescue is unknown, but the increasing number of so-called "boomerang" children or adult children who return to live at home with parents, often between jobs, marriages, or other setbacks offers indirect evidence that this form of inter vivos transfer is fairly common.

Sixth, in addition to financial assets, children inherit prospects for quality of health and life expectancy. There is overwhelming evidence of a wealth-health gradient in which the risks for illness, injury, and death are lower for higher socioeconomic groups. This pattern has multiple causes, beginning with prenatal care and extending through old age. Individuals from wealthier families have better diets, health care screening and prevention, intervention, and access to high quality health care. Childhood protection from exposure to disease and health risks can influence later quality of health and earning capacity, and are therefore forms of parental inheritance.

Finally, children may be the beneficiaries of bequests from parental estates. While only about 20% of U.S. households report receiving bequests, as familial wealth increases, the chances of receiving such bequests also increase. When bequests of bulk estates are made, they often involve substantial amounts, and are a major mechanism though which economic inequality is reproduced across generations.

Disadvantages of Inheritance

The most obvious disadvantage associated with inheritance is the familial conflict that results from

disinheritance or the contesting of a will. Furthermore, in societies that particularly value individual achievement and meritocracy, recipients of inheritance may experience a form of cognitive dissonance in which they feel guilty or unworthy of the privileges and advantages bestowed through inheritance. Inheritance or the prospect of inheritance can serve as a disincentive for individual achievement, bring unwelcome public scrutiny, jeopardize privacy, or even threaten one's security. On balance, however, the advantages of inheritance appear to outweigh the potential disadvantages.

Robert K. Miller, Stephen J. McNamee, and Abigail B. Reiter

See also Economic Impact of Death on the Family; Living Wills and Advance Directives; Postself; Quality of Life; Social Class and Death

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Instrumental Grieving: Gender Differences

It is suggested that different socialization experiences or biological differences cause men and women to exhibit distinct patterns in the way they experience, express, and adapt to grief. It is further suggested that the male role inhibits grieving because it emphasizes the regulation of emotional expression while diminishing the supposed need to seek support from others. Women, on the other hand, are more receptive to accepting help and more willing to express emotions, both of which are seen as facilitating the grief process. And Alan Wolfelt posits that men's grief is naturally more complicated because they cannot express emotion or seek help. Despite such claims, the research in the field of thanatology clearly challenges these perceptions.

Research Perspectives

Therapists' Views

In one study conducted during the 1990s, the analysts evaluated the views of certified grief counselors and therapists as these pertain to gender differences in grief. Their sample did hold to the belief that men and women expressed grief differently. To wit, men were perceived as less likely to express strong emotions and more likely to use diversions such as work, play, sex, or alcohol as avoidance strategies in lieu of grieving. Therapists reported that men were more likely to respond cognitively, and to use anger as a primary mode of emotional expression. Women were perceived as more likely to express grief affectively and to seek support. The counselors in the sample also found differences in the expectations and support men and women experienced from others. Others expected men to get over their loss more quickly and be able to function more effectively. Women were seen as needing and receiving more emotional support, but others also viewed women as more of a social risk who would be more likely to break down in normal social situations. The result was that these therapists reported their women clients received more comfort-oriented support but fewer

opportunities for normal social activity than their male counterparts.

Despite these differences in the expression of grief and the support level they are likely to receive, the counselors in this project did not report differences in outcomes. In fact, the therapists surveyed saw different risks for each gender. In their view, men were more at risk for certain types of complicated grief reactions, while women were more prone to depression or chronic mourning.

Gender-Based Studies of Grief

The perspective of therapists, explicitly or implicitly, is grounded in much of the research that shows a difference in the ways men and women grieve. Summarizing the extant literature that addresses this issue, during the late 1990s Terry Martin and Kenneth J. Doka note the following:

- Research on widows and widowers has shown that widows and widowers face different problems in grief. For example, many widows report financial distress and note the emotional support provided by their spouse. Widowers were more likely to report disruptions of their familial and social networks. Widows were more likely to seek emotional support, while widowers found solace in exercise, work, religion, creative expressions, or more destructively in alcohol.
- Many of these same results are evident in the loss of a child. Mothers reported more emotional distress than fathers. Strategies in dealing with the loss differed by gender. Women tended to use more support-seeking and emotion-focused strategies, while men were more likely to intellectualize their grief and use more problem-focused strategies to adapt to the loss.
- Studies of the loss of a parent also showed that middle-age sons were less likely than daughters to experience a high intensity of grief and somatic manifestations, and more likely to utilize cognitive and active approaches in adapting to loss.
- Differences between genders seem less apparent in older cohorts. This may reflect the idea that individuals become more androgynous as they age.
- Differences in gender are also affected by other variables, such as social class, cohort, and cultural differences.
- The research on differences in outcome is quite mixed. Some studies have shown men to have better outcomes, others show women to do better, while still other studies show no significant difference or mixed results in outcome (i.e., men do better on some measures, women on other measures).

This research does have implications for counselors. Whether one evaluates this difference as resulting from gender orientation or as patterns influenced by gender, the results suggest that different responses to loss can affect relationships within the family when a loss to that family is experienced. Assisting individuals to identify and discuss the ways they deal with loss and helping families to address how these differences affect each other's grief are important outcomes.

Patterns of Grief

It is suggested that we should look beyond gender to understand different pattern or styles of grief. Martin and Doka propose that these patterns are related to gender but are not determined by them. They suggest that gender, culture, and initial temperament interact to produce a dominant pattern of grief. They view these patterns of grief as a continuum. Martin and Doka further acknowledge that such patterns are likely to change throughout an individual's development, often moving more toward the center of the continuum as an individual moves to late adulthood. Based upon the underlying concept of emotion regulation, three basic patterns of grief are presented.

Intuitive

Intuitive grievers experience, express, and adapt to grief on a very affective level. Intuitive grievers are likely to report the experience of grief as waves of affect or feeling. They are likely to strongly express these emotions as they grieve—shouting, crying, or displaying emotion in other ways. Intuitive grievers are also likely to be helped in ways that allow them to ventilate their emotions. Self-help and support groups, counseling, and expressive opportunities that allow them to ventilate feelings are likely to be a useful strategy.

Instrumental

Instrumental grievers are more likely to experience, express, and adapt to grief in more active and cognitive ways. Instrumental grievers will tend to experience grief as thoughts, for example, a flooding of memories or in physical or behavioral manifestations. They are likely to express grief in similar ways—doing something related to the loss, exercising, or talking about the loss. For example, in one case, a man whose daughter died in a car crash found great solace in repairing the fence his daughter had wrecked. "It was," he shared later, "the only part of the accident I could fix." Instrumental grievers are helped by strategies such as bibliotherapy or other interventions that make use of cognitive and active approaches.

Dissonant

Dissonant grievers are those who experience grief in one pattern but are inhibited in finding ways to express or adapt to grief that are compatible with their experience of grief. For example, a man might experience grief intuitively but feel constrained from expressing or adapting to grief in that way because he perceives it as inimical to his male role. Similarly, a woman might also experience grief in a more intuitive way but believe she has to repress that feeling in order to protect her family. Counseling with dissonant grievers involves helping to identify their inherent pattern, recognizing the barriers to effective expression and adaptation, and developing suitable interventive techniques. In Western culture, many males are likely to be found on the instrumental end of this continuum, while women are more likely to be found on the intuitive end. However, although gender influences the pattern of grief, that pattern is not determined by gender. It is also noteworthy that many individuals in the center of the continuum may show more blended patterns, utilizing a range of emotion and behavioral and cognitive strategies to adapt to loss.

Implications

The concept of grieving styles and patterns is part of a general trend in the field of grief studies that emphasizes the individual pathways of grief rather than seeing the process as a universal and predictable series of stages. This has implications for grief counseling and grief support. First, grief counselors should carefully assess the ways that individual clients have tended to experience, express, and adapt to grief. This careful assessment is the first step in designing interventions suited to their grieving styles that build on their historic strengths.

There has been discussion of the value of more androgynous approaches—that is, designing interventions that seek to move people toward more blended styles. For example, Henk Schut, a researcher in the Netherlands, found in one study that women seemed to benefit more from cognitive-based therapies, while men found more value in affectively based approaches. However, as Martin and Doka noted, Schut's research was based on gender. Therefore, there was no knowledge of grieving styles prior to their participation in the research. Moreover, Martin and Doka emphasized that crisis is often a poor time to teach new modes of adaptation and that except in situations where previous adaptations have been unsuccessful, people do well to use their historic strengths. Nonetheless, these discussions reaffirm both the importance of assessment as well as the need to intentionally and individually design interventions that are sensitive to an individual's style or pattern of grief.

Second, organizations such as hospices, hospitals, grief centers, or funeral homes that offer grief support need to recognize that multiple approaches are likely to meet the needs of a wider range of clients than one approach. Counseling and support groups, for example, often appeal to intuitive and more dissonant grievers. Educational offerings on grief, a grief lending library, access to web-based resources, and even memorials and other types of ritual events may widen the organization's ability to support people who grieve in more instrumental ways.

Culture and Gender

Any analytical discussion of gender differences in grief or evaluation of patterns of grief that are influenced by gender should consider cultural differences. Culture influences grief in a number of ways. First, each culture has norms that govern the ways grief is appropriately expressed. In some cultures these norms can differ between genders. In one study conducted during the 1970s, Paul Rosenblatt

and his associates found that in the 60 societies surveyed, 32 had no differences in the expectation of crying between men and women. In the remaining 28 societies, women were allowed more emotional expressiveness. Also, each culture defines relationships in different ways, influencing the level of attachment. These, too, may differ by gender.

Conclusion

The concept of grieving styles or patterns reminds researchers, academicians, and clinicians not to place too much emphasis on gender alone. Gender and socialization to gender roles in any given society certainly influence grieving styles, but gender alone does not determine the ways that people grieve. The adoption of any given grieving style is influenced by other variables, including culture, temperament, as well as socialization and developmental experiences.

Kenneth J. Doka

See also Death Education; Disenfranchised Grief; Grief, Bereavement, and Mourning in Cross-Cultural Perspective; Grief, Types of; Grief and Bereavement Counseling

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Isolation

Isolation refers to the state of separation. It is an external, objective condition that can be measured and to some extent controlled. Dying is an isolating experience. In its most general meaning, isolation is separation or the absence of relatedness. Isolation is essential to understanding the nature of dying, for it is in dying that our relatedness to a surrounding world is undone. Because both isolation and dying causes one to withdraw from communication, the isolation of dying is difficult to understand. To illuminate its meaning, the relationship of isolation to dying is evaluated within the context of the following issues: identification of the isolative impact of dying, how such isolation is experienced, and how further understanding of the isolation of dying may be achieved.

Isolation of Dying

Isolation of dying refers to various conditions, the first of which is social isolation. Declining health, a decreasing social network, the loss of social roles, and loss of partner and family members often precede dying. Social isolation is exacerbated when one's family is distant and hospitals and nursing homes have restricted visiting hours. The second condition is emotional isolation. Overwhelmed by confused feelings pertaining to impending death, people experience difficulty expressing their feelings. Emotional isolation is exacerbated when inaccurate communication is offered by caregivers and loved ones who experience difficulty in confronting the dying. Third, the isolation of dying refers to existential isolation or being alone in facing death. Existential isolation may be exacerbated by dissociation from religious beliefs and by a lack of spiritual care. Depending on the type and duration of the illness, as well as on personal and health care circumstances, some ways of dying tend to be more isolating than others. However, dying not only isolates one from one's self and others but from life as well. Indeed, dying is a state of total isolation, making existential isolation unique to the isolation of dying.

Loneliness of Dying

Subjectively perceived and internally evaluated, isolation becomes an experience. Loneliness represents a negative aspect of isolation, the distress of being separated. When death is experienced in a negative way, the existential isolation of dying is

portrayed as existential loneliness. Existential loneliness refers to the terrifying experience of isolation that results from the awareness that one is a separate individual being. This fundamental separateness makes the experience of existential isolation an empty, timeless, and toneless quality. As dying eliminates all our relationships, existential loneliness of dying is the awareness of the absence of any other awareness, perception, or feeling.

Explication of the experience of existential loneliness of dying in terms of nonrelatedness makes this experience enigmatic. After all, it remains unclear how the absence of any relatedness may lead to an experience at all. The existential loneliness literature purports to solve this riddle mainly by means of a phenomenological theory of consciousness. Phenomenology claims that consciousness exists only by virtue of the fact that a subject is necessarily directed toward an object. Without this relationship, consciousness is nothing. In the case of dying, consciousness can no longer be directed to an object. As a consequence, consciousness becomes aware of its own nothingness. It is suggested that it is precisely this nothingness that is represented in the experience of existential loneliness and, together with that, in loneliness of dying. However, it is difficult to see how nothingness that results from the absence of relatedness can be explicated in positive terms. Therefore, it is claimed by some analysts that the existential loneliness of dying cannot be explicated other than by its own nothingness.

Solitude of Dying

Because isolation of dying cannot be further understood by a direct exploration of the experience itself, two other strategies are proposed for a more extended understanding of the isolation of dying. First, isolation of dying can be understood by recognizing one's own solitary nature. To do so, one has to withdraw into solitude—the positive experience of isolation. Through introspection and voluntary separation from others we confront our own finiteness. By doing so, we become aware that all the projects and plans we make are structured by our finitude. The awareness of finitude is thus a positive confirmation of life for it makes it possible to us to live our lives according to what we are: finite human beings. Most people, however, turn away from both solitude and a full awareness of being mortal. Because this avoidance may be explained as a self-protecting strategy, the claim that increased awareness of one's own finitude leads to a better understanding of isolation of dying seems to be without merit.

Second, the isolation of dying can be understood by exploring the philosophical presuppositions that underlie the conceptualization of existential isolation. As these presuppositions incorporate various anthropological claims concerning human's lonely nature, their explication brings to light subtle but important differences in understanding the experience of isolation. Elaboration of these differences in the context of dying illuminates which circumstances and interventions cause deterioration or amelioration of the experienced isolation. Questions as to what these circumstances and interventions are have yet to be the object of further empirical research.

Eric J. Ettema

See also Atheism and Death; Awareness of Death in Open and Closed Contexts; Death Anxiety; Disengagement Theory; Language of Death; Spirituality

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Jewish Beliefs and Traditions

For the Jew, beliefs about life and death are firmly rooted in the world of the living. Judaism has no dogma concerning what happens to a person after death (such as heaven and hell). Rather, a Jew is taught to live life to its fullest and perform deeds of loving kindness for as many people as possible. Rewards and punishments for behavior occur in this world, but also affect our final status in the world to come. Life is so precious that saving a life is the highest ethic and demands the breaking of all other *Mitzvot* (commandments) in order to do so. Further, death is regarded as a natural part of being human. The story of Adam and Eve explains the introduction of death to the world. Adam and Eve were dismissed from the Garden of Eden to avoid becoming like the angels, living eternally yet childless by continually eating from the tree of life. Instead, human beings were meant to leave progeny and live for a limited time. Judaism, like other religions, focuses on coping with the reality that although human beings may wish to live forever, the body is mortal. A dominating theme in Judaism is that one continues to live on after death in the memories of one's children and grandchildren, which is reinforced with rituals and memorialization. Judaism must help its adherents recover from the trauma of death to return to the world of living despite the absence of a loved one. To do this, the mores of Jewish law cover three areas: (1) care and disposition of the remains, (2) acclimation of the mourner to a new life, and (3) keeping the deceased's memory alive. Within a Jewish religious and cultural framework, the mourner can depend on these traditions to treat the deceased with dignity, help ease the pain of bereavement, and memorialize loved ones. Rich in symbolism, ritual, and spirituality, the phases of Jewish mourning carefully bring the bereaved through the anguish of grief using the structure of ancient traditions and the support of the community.

Care and Disposition of the Remains

Jewish law defines the mourner as a parent, spouse, child, sibling, or half sibling. While extended family and friends certainly grieve, only the mourner is required to observe the following laws. Upon learning of a death, the mourner enters a period of *ahneenoot* (mourning, literally, being thrown into a world of chaos). All daily rituals are suspended and every effort is directed toward preparing for the funeral. The general rule is that burial should occur within 24 hours of death.

Jews consider the body, the sacred vessel of the soul, as created in the image of God; therefore, it is to be cared for with the utmost respect. The body is not to be left alone from death until burial. It is to be watched over by a *shomer* (guard), lest rodents or body snatchers molest it. Specially trained members of the community (the *Chevra Kadisha,* or Jewish Sacred Society) prepare the body by washing it with a solution of water, vinegar, and eggs. During this solemn ceremony known as *t'hara* (cleansing), the members of the

Chevra Kadisha recite prescribed benedictions and psalms and do not engage in trivial conversation.

The body is dressed in *tachrichim,* which are hand-sewn shrouds made of linen or muslin that are without pockets. These garments indicate that all people are identical, regardless of status, and that there is no need to carry anything to the next world. This tradition arose because at one time in Jewish history people would desert the body of their loved one when they could not afford the high cost of new garments and fancy caskets. Thus, in the 1st century C.E., Rabbi Gamliel made an official declaration that everyone would be buried in identical clothing and similar plain caskets.

There is no public viewing of the body. Because burial occurs quickly, the body is not embalmed. Tradition dictates that people are to be buried with their body intact; thus, an autopsy is not allowed except when required by law. The body is then placed in an *aron* (a plain wooden casket, see photo). No metal is to be used because metal brings to mind implements of war, adornment of a casket can be expensive, and metal deteriorates at a slower rate than the body itself. The use of flowers to mask the smell of a decaying body arose in cultures that delay the funeral for several days. Flowers are now used as a memorial and expression of condolence, but are not seen at a Jewish funeral. Instead, family and friends donate *tzedakah* (charity) to a fund or cause that was important to the deceased.

Funeral Service and Burial

The *l'vaya* (funeral service) consists of reading Psalm 23 and other psalms, a eulogy consisting of *hesped* (praise of the deceased) and *b'chi* (an expression of the family's grief). The service concludes with the reciting of the *El Malay Rachamin* (God Full of Mercy), a prayer asking God to bring the deceased person back under God's sheltering wings.

Kriah (a tear) is made in the mourner's clothing or on a ribbon attached to the clothing. This external symbol of inner grief signifies that a loved one has been torn from one's life. Kriah is performed on the left side for a parent and on the right for all other relationships. This rending of the mourner's garment gives an appropriate indication of bereavement without marking the body, which was an ancient pagan practice.

At the cemetery, the pallbearers make several stops on the way to the grave to show reluctance to perform this act. The body is then buried in the earth. Cremation is not a traditional form of disposing of the body and, in fact, is against Jewish law. In Israel today, due to the desert climate and scarcity of wood, caskets are not often used, and it

Plain pine casket—no metal used

Source: Ark Wood Caskets.

is not unusual to bury the deceased directly in the ground. In an Orthodox burial, crockery is sometimes placed over the orifices so as to block the soul's return to the body. An observant Jew may be buried in a coffin with a bottom that slides out so that the body touches the earth. Some religious Jews make prior arrangements to be buried in Israel to be closer to the place of Judgment when the Messiah comes. For a burial outside of Israel, Israeli dirt is added to the coffin to provide a connection to the Holy Land and to be a guide at the time of resurrection (one of Judaism's many beliefs about life after death). The grave is filled in completely by those present to reinforce the reality of the death.

The service at the cemetery concludes with the recitation of the *Kaddish* prayer. The mourners leave the gravesite through a double line of friends and family as the following Hebrew words are spoken: *Ha-makom y'nachem etchem b'toch aveley Zion v'Yerushalyim* (May you be comforted among the mourners of Zion and Israel).

Acclimation to Life Without the Deceased

With the death of a loved one, chaos ensues. However, the continuation of life and living is *sine qua non* in Jewish thought. To bring order back to life, Judaism dictates *aveelut* (withdrawal from the community) for a 7-day period. After the funeral, the next weeklong phase of the mourner's life begins: *shiva,* meaning seven. The day of burial is the first day and the last day one needs observe for only 1 hour.

Upon returning home after the funeral, the mourner and everyone who was at the cemetery washes their hands ritually before entering, a custom that symbolically washes away the "evil spirits" and ritual impurities associated with death and the cemetery. Immediately, the mourners are commanded to partake of a *se-udat havra'ah,* a meal of recuperation or consolation. They begin by eating a hard-boiled egg, symbolic of ongoing life. A dairy meal is served because dairy is easy on the digestive system and this is often the first meal the mourners have eaten since the death. The community provides the se-udat havra'ah, a tradition that ensures that the mourner is not alone and reminds the bereaved that he or she must continue with life. During the shiva period, mourners are directed to sit upon low stools and remove leather shoes to reflect the humble feeling that they are experiencing. A tall candle that burns for 7 days is lit.

The first 3 days of shiva are the most intense and are the minimum number of days of mourning. Those who visit the bereaved during this period are instructed not to offer words of comfort, but only to sit with the mourners and wait for

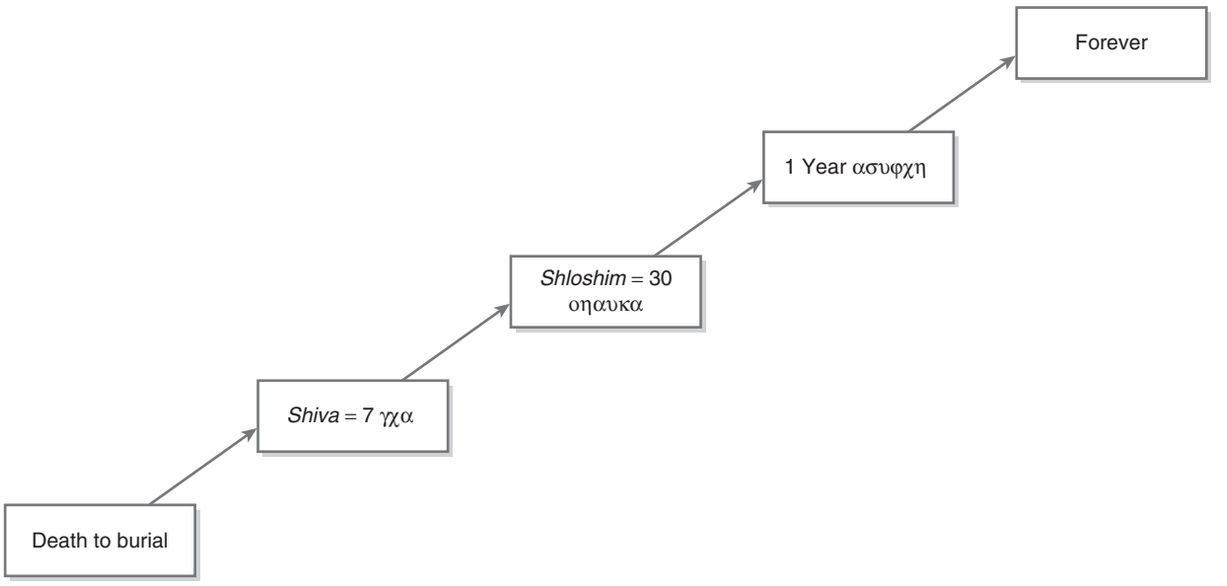

Figure 1 Timeline for Jewish Mourning

them to speak. Shiva is for one purpose only: to help the mourners explore the emotional catalog of regret, relief, guilt, anger, shame, self-pity, and remorse. During the shiva period, the mourners slowly move from withdrawal to socialization. In observant homes, a *minyan* (prayer quorum of 10 adults) will pray together 3 times a day to enable the bereaved to say requisite prayers without having to leave the house. In less observant homes the minyan usually meets only in the evening. These gatherings also provide a community of support, which the mourner can count on without having to ask. If one is a doctor and needed in the community, or a day laborer who is the sole provider for the family and it is a financial necessity, the mourner may return to work but must take time during the day to grieve.

During shiva mourners are exempt from all requirements of daily life and are restricted from its pleasures as well. They are not to bathe or shower for pleasure (they can if required due to body odor). They are not to cut their hair, shave, or put on freshly laundered clothes, for they should concentrate on their loss and not on their appearance. Mourners are not to engage in sexual activity, but can engage in other forms of intimacy. Mourners are not to study Torah, for this is a source of pleasure for many. Mirrors in the home are covered to prevent mourners from gazing on themselves and engaging in vanity.

Shloshim (literally, 30 days) is the second, less intense period of mourning. The counting begins from the date of death. During shloshim, mourners are not to attend weddings, bar or bat mitzvahs, or other joyous events with music. Mourners are not to get married during this period, nor are greetings to be extended to them, but they can extend greetings to others. Instead of praying at home, mourners are to join the minyan 3 times a day in the synagogue. When mourning for parents, one prays in the synagogue for 11 months and does not attend joyous events or listen to music for *yud-bet hodesh,* a 12-month period from the date of death. During this year one does not shave or cut one's hair, unless someone remarks about it being unkempt.

Keeping the Deceased's Memory Alive

In response to fears that loved ones will be forgotten, Judaism created *Yiskor,* a structure of remembrance. Yiskor is observed 4 times during the year: on Yom Kippur (the Day of Atonement) and the three festival holidays (Passover, *Shavuot,* the Feast of Weeks or Pentecost, and *Sukkot,* the Harvest Festival). The deceased is memorialized a fifth time during the year on the *yahrzeit,* the anniversary of the day of death. These traditions acknowledge that mourning goes on forever and the deceased are never really forgotten. On these five occasions the Kaddish prayer is recited by the children of the deceased and other mourners as previously defined. Written in ancient Aramaic, the Kaddish does not mention death at all but, rather, praises and thanks God for having lent our loved one to us. Because it is not unusual for the bereaved to have feelings of guilt, reciting Kaddish also gives people a sense that they can still affect the deceased in the world to come. By reciting Kaddish, the mourner tells God that the deceased is remembered for all of their good and worthy deeds. The observance of yiskor and yahrzeit is done in a minyan so that the bereaved realize that he or she is not alone in mourning. In addition, a contribution to charity is usually given in memory of the deceased on the yahrzeit.

As part of the system of remembrance, after a period of time the family and the community return to the cemetery to dedicate a *matzevah* (tombstone). In Israel the custom is to do this at the end of a month. In other countries it is usually between 11 and 12 months after the death (timing can vary depending on climate). Written on the matzevah is the person's name in both their native language and in Hebrew and the dates of birth and death. Sometimes an epitaph is included. Upon visiting the cemetery, rather than flowers, Jews leave a stone on the matzevah as a permanent marker that they were there. During the Ten Days of Repentance, between Rosh Hashanah and Yom Kippur, it is traditional to visit the cemetery and say a prayer at the graveside. It is not unusual for an additional memorial in the name of the deceased to be dedicated in a public place, a synagogue, or a community building, or for a philanthropic fund to be established in their memory. Another way of memorializing the deceased is to name a child after the person, not only to keep their memory alive, but also in hopes of passing on their best qualities to the next generation. Jews often acknowledge the death of a person when mentioning their name by

saying *alav ha-shalom* (may peace be upon him or her) or *zicharono livracha* (may his or her memory be for a blessing).

At times, life and death clash, such as when a death occurs within days of a wedding or immediately thereafter. In both cases, because living is the highest ethic for the Jew, life prevails and the celebration continues. The 7 days of marital bliss are observed first, then one observes shiva thereafter. Should other complications or questions arise, such as a delay in news of the death reaching the mourner, a rabbi should be consulted to determine the best way to observe the mourning period.

Changes to Traditions as Jews Encounter Other Cultures and Modernity

Wherever Jews have lived they have been influenced by the practices of the secular culture. For instance, Jews from Russia will gather before the open casket and wail and bawl openly. At times it almost seems that they want to throw themselves on the coffin as it is lowered into the ground. This is not traditional among American Jews. As Jews were assimilated, some of the more liberal adopted the customs of burying the deceased in dress clothes and metal caskets. As families have dispersed throughout the country or world, the burial may be delayed beyond the 24-hour period so essential mourners can be present. Also, with the rise in popularity of cremation, some Jews are choosing this less expensive manner of disposing of the body. Although the aforementioned traditions are the standard and guide, various modifications are observed depending on the mourner's culture and degree of Jewish observance.

Daniel A. Roberts

See also Body Disposition; Caskets and the Casket Industry; Christian Beliefs and Traditions; Eulogy; Funerals and Funeralization in Major Religious Traditions; Grief, Bereavement, and Mourning in Cross-Cultural Perspective

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JIHAD

Jihad is an Arabic word used principally by Muslims to connote spiritual struggle directed either to the internal cleansing of one's soul or toward external forces deemed to be a threat to the harmonizing of humankind with God's will. It is the latter interpretation that has likely led some non-Muslims to simplistically define jihad as "holy war," however for many (if not most) Muslims jihad is a complex idea not easily reduced to a simple recipe for action. For example, an internal struggle to purify one's soul also might call for externally directed actions in service to Allah's will, but such actions need not be aggressive, any more than the efforts of other proselytizing religions are necessarily aggressive. Nevertheless, scholars continue to search for consensus as to the true meaning of jihad in a debate that has been ongoing in the Muslim world for centuries and highlighted and intensified by recent terrorist events. Because it is essentially spiritual, jihad may be inextricably linked to both individual and collective conceptions of attitudes toward death and, as is well known, often leads to the deaths of *shaheed* (martyrs) and nonbelievers alike. There is disagreement among Muslims as to whether the Quran unequivocally forbids suicide or actually calls for martyrdom and/or the destruction of nonbelievers as the ultimate expression of Muslim faith. These debates aside, multiple social scientific explanations and analyses of jihad have been offered focusing on the various religious, economic, political, cultural, social, and psychological aspects of the phenomenon. Although most accounts are multidimensional, all tend to lead toward one or another discipline as a point of departure and may be

categorized accordingly. The categorization that follows is just one of many possibilities, as jihad remains a complex phenomenon.

Economically Centered Explanations

Analyses that focus on economic factors generally view jihad as a reaction to the modernizing and Westernizing influences of global capitalism. That is, jihad is understood as the reaction of a culture that perceives itself to be under threat from the blanketing effects of globalization. Capitalism is described as an economic system that has little regard for local traditions and noneconomic elements of social structure. Benjamin Barber, for example, characterizes jihad as a manifestation of a larger trend toward tribalism, that is, toward efforts to find an identity with a particular social or cultural group that might provide some defense against the destructive and homogenizing effects of global capitalism. Jihad has become the rallying cry for some Muslims who believe their values and traditions are being ground up in capitalism's blind pursuit of profit. Therefore they choose to respond to the juggernaut of global capitalism with an equally forceful and focused pursuit of Islamic traditions, albeit their own particular version of those traditions. Given that individual and collective identity are believed to be threatened with annihilation by this impersonal, secularizing, and foreign created system, killing of the just and the unjust alike is deemed unavoidable.

Politically Centered Explanations

Other efforts to explain and understand violent jihad take politics as the point of departure. The argument is that some Muslims are incensed by Western encroachments on the autonomy of Arab governments, particularly the occupation of Muslim lands by foreign elements. Whether the issue is the presence of U.S. troops in Saudi Arabia or Jews in Jerusalem, the fact that non-Muslims are thought to be defiling Muslim holy sites becomes a justification for violence. Indeed, many analysts have noted that al-Qaeda has repeatedly cited the presence of American forces in lands sacred to Muslims as reason for violent attacks against American targets. Of course, the focus on the political motivations of jihad does not preclude recognition of its economic, religious, and cultural dimensions, for these are often cited as interacting, contributing variables. Nevertheless, for some observers, the locus of power, especially as it relates to the control of land, is seen as the critical force behind the violence. Within this framework, violent jihad is understood to be driven primarily by a desire to restore political and territorial control rather than by the marginalizing effects of global capitalism.

Psychologically Centered Explanations

One popular argument regarding the motives behind *mujahidin* (those engaging in jihad) violence focuses on the vulnerability and naiveté of impressionable young suicide bombers enticed by the promise of heavenly bliss. In fact, inducements may include both the ethereal and the practical—the former including the fulfillment of sexual fantasies, perpetual reverence, and enhanced esteem for one's family, and the latter involving much needed financial support for loved ones left behind. Individuals willing to pay the ultimate price are designated martyrs, and martyrdom is defined as one of society's most valued social roles. Such psychologically centered explanations may apply to rich and poor alike, both the well-educated leaders of the September 11 hijackers and the impoverished teenager from the West Bank.

At the foundation of a psychologically centered argument is a personal frustration felt by some Muslims in the face of current Western dominance. Such arguments recognize the sense of frustration and humiliation that can be engendered by the economic and political imbalance between Muslim and non-Muslim countries, particularly given the past glories of Islamic civilization. When felt strongly, this perceived injustice can lead one to turn one's frustrations on symbols of Western power and influence in order to restore Islam to its rightful place in the world. A more nuanced examination of the psychological dynamics of terrorism, one that predates current concerns, centers on what many social scientists have identified as humankind's quintessential fear of death. Such theories presuppose that the human capacity to contemplate one's own mortality is the driving force behind much human behavior, including a penchant for warfare. These theories take many paths,

but one general line of argument is that we humans project our fear of death onto others whom we then kill as a means of controlling death and overcoming our inherent fear. Indeed, among the many insights of Robert J. Lifton into the connection between death and war is that the definition of an enemy is someone who must die so that we ourselves may overcome death. Thus, it could be argued that all who set out to kill an "enemy" are acting out of motives inherent to the human condition, whether in the name of jihad or of the state.

However, it should be noted that the definition of death in this context is something other than one's physical death. For many, mujahidin take their own life in furthering their cause. The pursuit of spiritual purification may indeed require personal sacrifice in order to bring about a larger collective purification that promises the end of death for all who believe. Psychological arguments notwithstanding, theories of jihad that center on this link between individual and collective struggles to overcome mortality often use religion as the starting point.

Religiously Centered Explanations

Jihad may be viewed as just one of a number of religiously motivated movements that see spiritual purity as a zero-sum-game in which the existence of other religious traditions can be a threat to one's own. Consequently, some adherents may feel compelled to diminish if not destroy those groups perceived as threatening to their own religious worldview. From this perspective, it is the underlying drive for spiritual purity pitted against external forces believed to be bent on compromising or destroying that purity that is responsible for violence. It matters little whether one's target is a doctor who performs abortions or an Arab politician believed to be too friendly with secularism. Such religiously motivated groups and individuals perceive themselves to be locked in a struggle with the forces of evil and are willing to use all necessary means to ensure the ultimate primacy of their religious doctrine and avoid spiritual annihilation for themselves and their coreligionists.

Given its currency in popular culture, a religiously centered explanation that deserves mentioning is one that attributes violent jihad to what some believe to be the inherently violent character of Islam. Support for this argument is said to be found in the historical record, particularly that of Islam's early conquest of the Middle East and its rapid spread to distant parts of Europe and Asia. It is suggested that the current incidence of Muslim terrorist violence is simply a modern manifestation of an innate quality of the religion. Such theorizing, however, seems to be found less frequently within the social sciences and, at best, simply moves the question of violence back to the origins of Islam and, at worst, makes simple work of what some consider to be a complex contemporary phenomenon.

Associating terrorism to the service of spiritual purification with humankind's anxious relationship with death, the sacrifice of self and others in service of a "higher" cause is neither a new phenomenon nor one unique to any particular religion or ideology. Some theorists observe that it has always been the business of warriors to lay their lives on the line. The fact that some willfully target innocents while others do not may open the door for debate over the morality of their actions, but it does not change the reality that historically humans have shown a willingness to sacrifice themselves and others in order to further a cause. To explain this willingness, some theorists have suggested that our species harbors a fear greater than physical death, and that fear, according to the sociologist Ernest Becker, is that life has no transcendent meaning; that all that we do and are is utterly without cosmic significance. Put simply, what humankind may fear more than all else is that life is without meaning or purpose, that there is ultimately no order in the universe and nothing to which we may anchor our existence. This prospect of chaos is something that we as self-aware animals cannot abide, so we create various defenses against mortality. Ideologies, religions, and belief systems are realities human beings generate to project order onto the potential chaos of the unknown and, having created a meaningful order, we will sometimes stop at nothing to preserve it. To do otherwise is to surrender to the possibility that life is utterly and totally insignificant.

Sociologist Peter Berger has argued that humans will engage in almost any behavior that is believed to ward off chaos, including self-destruction, if it is done in the name of some overarching meaningful order, or what he refers to as a nomos. In this

sense, when confronting death and sacrificing himself or herself, the suicide bomber establishes the significance of his or her particular version of Islam and ensures a meaningful place in the order of things for all cobelievers. Indeed, the mujahidin may well be convinced that all humankind will ultimately benefit from any actions that serve to harmonize humanity with the wishes of Allah. All are sacrificed to establish meaning and purpose for the human enterprise.

Given recent history, many have tried to come to some understanding of violent jihad and terrorist logic looking at various sociohistorical dimensions. Like the story about the blind clerics and the elephant, each perspective may capture only part of the phenomenon, but combining them—the economic, political, religious, cultural, and social psychological—can broaden the conversation and perhaps contribute to a resolution of one of the world's most intractable problems.

Harry Hamilton and Jeffrey Michael Clair

See also Altruistic Suicide; Assassination; Death, Psychological Perspectives; Death, Sociological Perspectives; Denial of Death; Fatwa; Martyrs and Martyrdom; Terrorism, International; Transcending Death; War Deaths

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Kamikaze Pilots

At the end of World War II, as a last ditch effort the Japanese military instituted the *tokkōtai* (or kamikaze) operations, in which pilots were asked, as a one-way mission, to dive into American aircraft carriers. Their voices defy the prevalent stereotype of "crazy chauvinistic zealots":

> "It is easy to talk about death in the abstract, as the ancient philosophers discussed. But it is real death I fear, and I don't know if I can overcome the fear."
>
> "Even for a short life, there are many memories. For someone who had a good life, it is very difficult to part with it. But I reached a point of no return. I must plunge into an enemy vessel."
>
> "To be honest, I cannot say that the wish to die for the emperor is genuine, coming from my heart. However, it is decided for me that I die for the emperor. . . ."

These words from Hayashi Ichizō, a graduate of the Imperial University of Kyoto who died on April 12, 1945, succinctly portray the death imposed on the young men who died as kamikaze pilots. In their opinion, they did not commit suicide, and no Japanese believed they did either.

Toward the end of World War II, when an American invasion of the Japanese homeland seemed imminent, Ōnishi Takijirō, a navy vice-admiral, invented the tokkōtai (Special Attack Force) operation, which included airplanes, gliders, and submarine torpedoes, none of which was equipped with any means of returning to base. Ōnishi and those closest to him thought that the Japanese soul, which was believed to possess a unique strength to face death without hesitation, was the only means available for the Japanese to save their homeland, which was surrounded by American aircraft carriers whose sophisticated radar systems protected them from being destroyed by any other means. Of the approximately 4,000 tokkōtai pilots, about 3,000 were so-called teenage pilots, who were drawn from newly conscripted and enlisted soldiers and enrolled in a special pilot training program. Close to 1,000 were student soldiers, university students who the government graduated early in order to draft. Although exact figures are hard to find, the available data shows the majority of those who died in the tokkōtai operation were student soldiers who were quickly promoted to officers. Of the 632 army officers who perished, 71% (449 pilots) were student soldiers; and of the 769 navy officers who perished, 85% (655 pilots) were student soldiers.

Unfortunately, the teenage pilots left almost no written legacy, but the writings left behind by the student soldiers offer invaluable testimony to these young men's struggle to sustain their connections to the rest of humanity amid the wrenching conditions of war and to make meaning of a death they felt was decreed for them. These extraordinarily well-educated youth were reflective and cosmopolitan, able to read the classics as well as the philosophies

and literature from Germany, France, Russia, and elsewhere, sometimes in the original language. They drew on their knowledge of philosophy and world history to try to understand the situation in which they inadvertently, but inescapably, were placed. Many of the student soldiers were political liberals or even Marxists or other radicals.

Since the end of the 19th century, as Japan began to modernize, the Japanese government faced the fact that Western colonialism was encroaching into the Far East, with Japan being the only nation that was not colonized. The first task for the Meiji government was to build a strong military, for which they adopted the motto, "Thou shall fall like beautiful cherry blossoms after a short life." This motto was relentlessly disseminated through textbooks, school and popular songs, films, theatrical performances, and so forth. This was the darkest period in Japanese history for young men. From elementary school onward, they were told that their lives should be sacrificed for Japan *qua* emperor. The Tōjō government graduated university students early twice, and all graduates, other than those in education and the sciences, were drafted.

Those who were forced to "volunteer" to be kamikaze pilots repeatedly said they feared death, and many said that they would rather die soon, rather than wait in uncertainty. Because these soldiers were assigned to these missions, they really did not commit suicide. Some stated that the government murdered them. They were similar to those soldiers from any nation or society who were drafted and sent to battlefields where death was guaranteed.

These young pilots read thousands of books trying to find meaning and rationalize their death at such an early age. Most of them were not married, and while some had experienced only platonic love, others were intensely in love with women they had to leave behind. As their death approached, they wrote more and more poems, crying out for their mothers and lovers. Hayashi Tadao, a graduate of the Imperial University of Kyoto, wrote a poem the night before his death on July 27, 1945:

Dusk, that most beautiful moment…

With no pattern

Appear and disappear

Millions of images

Beloved people.

How unbearable to die in the sky.

Kasuga Takeo, who looked after the daily routines of the student soldiers at the Tsuchiura navy airbase, describes how the night before their final flight turned into mayhem. They drank cold sake—some broke hanging light bulbs with their swords, others threw their chairs through the windows, while others tore white tablecloths. While some shouted in rage, others wept aloud. They thought of their parents and lovers. Although they were supposedly ready to sacrifice their precious young lives the next morning for Imperial Japan and for the Emperor, they were torn beyond what words could express. Some put their heads on the table, some wrote their wills, and others danced in a frenzy while breaking flower vases. The next morning, they all took off wearing the rising sun headband. Kasuga wrote how this scene of utter desperation, which he saw with his own eyes, had hardly been reported. He added that they had gone through incredibly strenuous training, coupled with cruel and torturous corporal punishment as a daily routine, only to be sent off to their death.

Emiko Ohnuki-Tierney

See also Shinto Beliefs and Traditions

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Karoshi

Karoshi means "death from overwork." Although the direct cause of death may often be a heart attack or stroke, the concept of karoshi implicates mental and physical exhaustion from an excessive workload over a long period of time as the underlying cause of such fatal physical ailment. The phenomenon first received public recognition in Japan in the 1980s, during the period of rapid economic growth and an increased work demand on corporate employees. Similar phenomena are also reported in other industrialized nations, such as the United Kingdom and the United States.

Throughout the 20th century and particularly during the post–World War II era, Japanese corporations emphasized teamwork and employees' loyalty to the corporate collective as a means to increase efficiency and productivity. They developed a human resources strategy to nurture these values in their predominantly male core employees, including lifetime employment, or the practice of retaining their employees for the length of their career whenever possible, and seniority-based promotion, or the pay scale that depends on the length of service, instead of performance or qualification of individual workers. Corporate employers rewarded their loyal core employees with generous compensation, both tangible and intangible, and encouraged social activities among employees to build a sense of belonging. In turn, male core employees, who are often referred to as "salarymen," became highly dependent on their corporate employment, both financially and psychologically. In general, these strategies were highly successful, and Japanese corporations and the economy throughout the latter half of the 20th century greatly benefited from this system.

The emphasis on teamwork and loyalty has also had significant effects on the day-to-day work practice in Japanese corporations. Unpaid overtime—in which employees do not declare their overtime work and therefore perform additional duties without pay—has been a routine practice that workers often understood as necessary and obligatory at times of high work demand, even if their supervisors did not specifically ask. In addition, the majority of Japanese workers hesitate to leave work at the official closing time of 5 p.m. if anyone else in their team or section was staying behind. Finally, the line between work and leisure is often blurred, or even nonexistent, as many salarymen's social network is almost exclusively based in their world of work. Thus, after work social activities and weekend outings with coworkers, bosses, and/or clients cut further into already diminished personal time. As a popular 1980s television commercial portrayed, Japanese salarymen are expected to "work 24 hours a day" and be the most productive *kigyo senshi* (corporate warrior).

Within the context of this work environment, it is not at all surprising that karoshi became a major social issue in the 1980s, as Japan was entering the unprecedented *baburu* (or bubble) economic boom. During this period, Japan's economic machinery was literally in a frenzy, and there was, it seemed, always more money to be made, which meant for an ordinary salaryman, more work to be completed every day. Because of the deeply instilled ideology of corporate loyalty, many of these workers obliged without hesitation. It was not unusual for them to stay in the office until 11 p.m. or midnight, 6 to 7 days a week, and work 70 to 80 hours per week on a regular basis. If work hours in themselves seem inhumane, the pressure to meet tight deadlines and outdo ever-stiffening competition also exacerbated the level of stress that these workers experienced.

While exhaustion and even death of salarymen from excessive work demands were an increasingly familiar occurrence among Japanese workers and their families throughout the 1970s and the early 1980s, there was little public recognition of the linkage between overwork and sudden death. Families of karoshi victims were not entitled to receive Workers' Compensation benefits and were often forced to depend on the largesse of their deceased breadwinner's employer, who often paid out a substantial sum of money to the family. In return, families often refrained from airing their grievances in public arenas.

In the latter half of the 1980s, families of karoshi victims began to take their cases against the corporate employers and the Workers' Compensation Program to court, and this was when karoshi became a highly visible social problem. The Japanese Ministry of Labor, protective of corporate interests, was reluctant to acknowledge the legitimacy of karoshi claims, and the only

support system available to the victims' families came primarily from grassroots organizations, such as the National Defense Counsel for Victims of Karoshi, an organization of attorneys concerned with the legal rights of those impacted by overwork and death.

Legal decisions emanating from Japan's High Courts during the early 1990s established the connection between overwork and sudden death, prompting the Japanese government to make, albeit slowly, policy changes. While situations are improving, karoshi claims continue to be difficult to establish under the Ministry of Labor guidelines, and many families of karoshi victims, discouraged by a prolonged and burdensome process, do not file a claim for compensation.

The face of karoshi began to change in the 1990s, however, as the bubble economy abruptly ended and Japan entered a long period of recession, known as *Heisei Fukyo*. While the work demand appeared to ease up, different sources of stress began to affect corporate workers. Japanese corporations began radical restructuring and downsizing to survive in the global competition, and corporate paternalism eroded quickly. Layoffs caught many salarymen by surprise. They assumed that they had a stable job for the rest of their productive lives. Those who were able to hold on to their jobs discovered that their workplace turned into a place of severe competition where each individual worker is held responsible for establishing measurable results. Overworked, alienated, and stressed beyond their limit, Japanese workers in their midcareer increasingly began choosing death to escape the situation, and the suicide rates significantly increased during the late 1990s and early 2000s. Many of the suicide cases are thought to be *karojisatsu* (suicide triggered by excessive stress from work), a new subcategory of karoshi that reflects Japan's changing economic reality.

Sawa Kurotani

See also Causes of Death, Contemporary; Causes of Death, Historical Perspectives; Mortality Rates, Global

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Kübler-Ross's Stages of Dying

Elisabeth Kübler (1926–2004) described herself as stubborn, opinionated, independent, and unconventional. As a youth growing up in Switzerland, she was determined to become a doctor despite a childhood experience of hospitalization in which she was isolated and separated from her family by what she viewed as an impersonal and uncaring system.

After qualifying as a physician and marrying a fellow medical student from America, Emanuel ("Manny") Ross, the couple moved to the United States. As a new doctor, Kübler-Ross accepted a residency in psychiatry because becoming pregnant disqualified her from one in pediatrics.

In the fall of 1965, Kübler-Ross was a faculty member at a University of Chicago hospital when four theological students asked her to help them understand death as the ultimate crisis in life. She offered to identify dying patients with whom to conduct interviews, but many of the other physicians at the hospital were critical of their new colleague. They were concerned about exploiting vulnerable patients and unwilling to grant access to their patients. Still, by early 1967, Kübler-Ross was leading an unorthodox but popular weekly seminar in which she would interview a patient behind one-way glass with subsequent discussion after the patient had left.

In 1969, an article in *Life* magazine and publication of what was to become an international best seller, *On Death and Dying,* led to worldwide fame and countless requests for Kübler-Ross to give

interviews, lectures, and seminars on subjects that soon became the focus of her professional life.

Kübler-Ross had views on many subjects, including the afterlife, spiritual guides, out-of-body experiences, and near-death experiences, but she is best known for her theory of the five stages of dying.

The Five Stages

The stage theory of dying arose from interviews that Kübler-Ross conducted with some 200 adult patients over a period of roughly 3 years. Each of the stages can be associated with a typical expression.

Stage	*Typical Expression*
1. Denial	"Not me!"
2. Anger	"Why me?"
3. Bargaining	"Yes me, but…"
4. Depression	
Reactive	Responding to past and present losses
Preparatory	Anticipating and responding to losses yet to come
5. Acceptance	Described as a stage "almost void of feelings"

Each stage of the theoretical model represents a typical human reaction:

1. Denial involves reactions to the shock of the diagnosis. It reflects unwillingness to acknowledge or outright rejection of the fact that one is dying. Denial is also a kind of protective barrier aimed at holding off the implications of terminal illness.
2. Anger arises when denial can no longer be sustained. It at least partially acknowledges that the individual is dying but also complains this is not fair or right. Anger is often projected toward care providers, God, or other perceived contributors to the illness.
3. Bargaining involves resignation combined with efforts to regain some degree of influence by focusing (realistically or unrealistically) on what might be done to postpone death or arrange for that outcome to occur in ways more acceptable to the individual in return for pledges of various types to God or the doctors (Kübler-Ross did not expect most individuals to keep these promises).
4. Depression focuses on the individual's sense of loss, either on past and present losses, or on future, anticipated losses, such as the expected loss of all love objects.
5. Acceptance is described as a reaction when the end may seem positive or there may not be enough strength to live. Different individuals may experience acceptance in different ways, ranging from looking forward to impending death as relief from suffering or an opening to the afterlife, on the one hand, to grudging acknowledgment of one's fate, on the other hand.

Kübler-Ross suggested that with adequate time and support dying people can or may work through each of these five stages. She emphasized that hope usually persists throughout, informing care providers of the importance of allowing dying people to sustain hope, whether or not the care provider agrees with the form hope takes. This important aspect of the theory has often been overlooked.

Appreciating the Goals of the Theory

Kübler-Ross wanted to tackle the depersonalization and dehumanization she found to be a critical aspect of the experiences of many dying people. She believed the attitudes of care providers and health care systems often contributed to the loneliness and isolation perceived by many dying people, as well as their sense of helplessness and hopelessness. She emphasized the importance of "taking the role of the other": to imagine oneself in the position of these patients, to try to understand their reactions rather than judging them, and to seek to learn from them.

Kübler-Ross variously described the five stages as reactions, defenses or defense mechanisms, coping mechanisms, and adaptations. She depicted her theory as a general model or categorization of experiences many individuals have when facing awareness of their own finality. According to Kübler-Ross, each stage can last for different periods of time in different individuals. Some stages may replace others, while others may exist at times

side by side. In other words, the five stages represent a typology of some prominent psychosocial reactions to experiences that may be associated with dying. Kübler-Ross also argued these types of reactions are not confined solely to dying people. Indeed, as important components of the human experience, these reactions may also be experienced by others who enter into the experiential world of those who are dying, including family members and care providers.

Kübler-Ross described the five stages in her theory in broad terms. For example, denial and acceptance are essentially presented as opposites on a continuum. Although the other three stages—anger, bargaining, and depression—may vary in intensity, character, and focus, they appear mainly as transitional reactions experienced in the process of moving from denial to acceptance. Denial and acceptance are each formulated in ways that allow them to apply to a spectrum of reactions: from a complete rejection of one's status as a seriously ill person to an unwillingness to admit one is dying or that death is more or less imminent, on one hand; and from acknowledgment, resignation, and acquiescence to welcoming death, on the other hand.

Denial is described as a healthy way for dying people to cope with their situation. Kübler-Ross wrote that almost all patients use at least partial denial, both during the initial confrontation with serious illness and also later on from time to time. Denial serves as a buffer against unexpected and shocking news, while enabling individuals to collect themselves and, perhaps with time, to mobilize other less radical defenses.

Evaluating the Stage Theory of Dying

The model proposed by Kübler-Ross helps normalize and humanize the experiences of dying people by demonstrating that dying is a human process, not merely a series of biological events. It drew attention to challenges encountered by dying people and to their needs as living human beings. The theory became readily accepted within the popular culture perhaps because it describes reactions to a difficult situation in ways people can easily understand. The model also allows others to contemplate their own reactions when interacting with a dying person. In addition, the theory argues against the view that only mentally deranged or suicidal people could truly accept their deaths. In all of this, Kübler-Ross was an early and important contributor to the death awareness movement. She also helped establish the atmosphere in which the modern hospice movement developed.

Still, there have been serious criticisms raised against this stage theory of dying. First, scientific research has not supported this model. Kübler-Ross herself offered nothing beyond the authority of her own clinical impressions and illustrations from selected examples to sustain her theory. She advanced no further evidence to support or confirm the efficacy of the model, although she continued to assume its reliability as obvious. Nevertheless, there has been no independent confirmation of the validity or reliability of the theory, and the limited empirical research that is available does not confirm this model.

Second, the five sets of psychosocial reactions at the heart of the theory can be criticized as overly broad in their formulation, potentially misleading in at least one instance, insufficient to reflect the full range of human reactions to death and dying, and inadequately grounded for the broad ways in which they have been used. The expansive way in which these five reactions are formulated has already been noted.

Kübler-Ross did not invent these five reaction patterns; her inspiration was to apply them individually to the human experiences of dying and facing death, and to link them together as part of a larger theoretical schema. Among its peers, the stage of depression seems curious as an element in a healthy, normative process of reacting to dying—unless it really means sadness—because clinical depression is a psychiatric diagnosis of illness. Moreover, we need not believe there are only five ways in which to react to dying and death. Finally, Kübler-Ross herself applied this theory to children and those who are bereaved in ways not warranted by its original origin in interviews with dying adults.

Third, the theory has been criticized for linking the five reaction patterns together as stages in a larger process. In part, Kübler-Ross seems to have agreed with this point because she argued for fluidity, give and take, the possibility of experiencing more than one of these reactions simultaneously, and an ability to jump around from one stage to

another. If so, this is not really a theory of stages, which would involve a linear progression and regression like steps on a ladder or calibrations on a thermometer. In short, the language of "stages" seems inappropriate for what are essentially clusters of different psychodynamic reactions to a particular type of life experience.

This last point is important because some have shifted the emphasis of the theory from description (this is how some people react to impending death) to prescription (this is how people should or ought to react to impending death). Thus, some practitioners may create the reality when they inform dying people they have already experienced one of the five stages and should now move on to another, while others complain about individuals who they view as "stuck" in the dying process. When coupled with the limits imposed by only five general categories of reaction to dying, this tends to suppress the individuality of dying people (and others) by coercing them into a rigid, pre-established framework in which they are expected to live out an agenda at the end of life that is imposed on them by others. This is particularly ironic because Kübler-Ross set out to argue that dying people are mistreated when they are objectified and dealt with in stereotypical ways. As a result, what seems to be widespread acclaim for this theory in the popular culture arena and in certain forms of professional education contrasts with sharp criticism from scholars and those practitioners who work with dying people.

Lessons From the Stage Theory of Dying

Three important lessons to learn from this stage theory of dying are implicit in the Preface to *On Death and Dying*. The first lesson is that those who cope with dying are living human beings who will react in their own individual ways to the death-related challenges that confront them and who may have unfinished needs they desire to address. The second lesson is that others cannot be effective providers of care unless they listen actively to those who cope with dying and work with them to identify their psychosocial processes and needs. The third lesson is that we all need to learn from those who are dying and coping with dying—to view them as our teachers—in order to come to know ourselves better as limited, vulnerable, finite, and mortal, but also as resilient, adaptable, interdependent, and worthy of love. Such characteristics can only enhance the human experience.

Charles A. Corr

See also Death, Clinical Perspectives; Death, Humanistic Perspectives; Death, Psychological Perspectives; Death, Sociological Perspectives; Death Anxiety; Death Awareness Movement; Death Care Industry; Defining and Conceptualizing Death; Hospice, Contemporary; Hospice, History of

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LAMENTATIONS

Lamentation is the ritual mourning of the dead through the collective rather than individual voicing and physical display of grief, usually over the corpse, prior to inhumation or cremation. The word *lamentation* is derived from Latin *lamenta*, which describes a wailing, weeping, or moaning. Synonyms include *dirge*, *threnody*, and *elegy*, but each term has its own oral and literary tradition. Mourning rituals, within the prescribed time between death and burial, vary according to religion. In the West, the evolution of ancient rites continues to impact contemporary expressions of lamentation.

The ritual of grieving over a corpse is of great antiquity and appears in the Epic of Gilgamesh, when the hero mourns for his companion Enkidu. In ancient Greece, the ritual expression and display of grief were both private and public acts. On the second day after death, the corpse was laid out (*prothesis*) for private mourning prior to the public ceremony accompanying the transportation of the corpse (*ekphora*) for burial or cremation at which lamentation dirges were sung. Lamentation is attested in Homeric epic: During the funerals of Patroklos and Hektor in the *Iliad,* both men and women engage in public lamentation that involves the ritual voicing of grief through dirges, the striking of breasts, the scratching of cheeks, and rolling in the dirt.

Later in Greek culture, however, only women and professional female mourners participated in public lamentation. The earliest depictions of lamentation (8th century B.C.E.) are found on large vases (amphorae or kraters) of the archaic geometric period that served as grave markers in the Dipylon Cemetery in Athens. Stylized representations of mourning scenes include the prothesis of the deceased surrounded by female mourners who lift their hands to their heads as a gesture of lamentation. The Choruses of Greek tragedy often incorporate threnodies in their odes.

The Old Testament book of Lamentations contains lamentations in verse that focus primarily on the destruction of Jerusalem and Solomon's Temple in 586 B.C.E. Although not a part of funerary ritual, the laments still hold religious relevance and are read aloud: Orthodox Jews mark the anniversary of the destructions of both Solomon's Temple and Herod's Temple by reading the verses on the 9th day of Ab. The verses are also read aloud at the Western Wall in the city of Jerusalem. As part of the Catholic liturgy, the verses are read aloud in the final 3 days of Holy Week.

In ancient Rome, funerary ritual was a blend of Greek and Etruscan practices. Early legislation forbade excessive expenditures or prolonged grieving through repeat burial ceremonies to curb aristocratic competition and to avoid extensive contact with corpses. Professional undertakers served as funeral directors who organized public expressions and displays of lamentation at wakes and funerals that were performed by female family members and professional female mourners. Since the middle Republican period (3rd to 2nd centuries

B.C.E.), dirges of lamentation and praise (*nenia*) were sung by a professional mourner to the sound of a flute. Gestures accompanied public lamentation and varied little from the archaic Greek period (8th to 6th centuries B.C.E.), attesting to the universality of a shared physical vocabulary of raised hands, the beating of breasts, and a disheveled and dirty appearance. Spontaneous expressions of grief and lamentation (sometimes accompanied by violent behavior such as the destruction or burning of public buildings and monuments) were often voiced by the urban mob in Rome to show sympathy for the death of a political figure such as Julius Caesar. The literary genre of epicede both elevated the expression of grief and consolation to survivors and extended the period of bereavement into a more private and meditative period of grieving.

The Christian influence on traditional Mediterranean expressions and displays of lamentation was profound and long lasting. The early Christian Church viewed death as a happy occasion because the soul would be reunited with Christ; therefore, Christians viewed contact with corpses less apprehensively than did pagans or Jews (due to baptism) and viewed the departure of the dead as a cause for celebration. Private and meditative mourning through hymns and prayer replaced the public lamentation rituals of pagans with their emphasis on wailing and the self-infliction of physical pain to reflect inner grief.

Mourning remains largely a private and relatively quiet activity (the uncontrollable grief of an individual, however, may always manifest itself at funerals) in the West regardless of religious denomination. Even in Hindu funeral ritual, there is no crying for the deceased during cremation, but grieving is permissible at home. Although the deceased may be remembered in prayer and narratives delivered by family and friends, quiet mourning accompanies the viewing of the deceased in funeral homes and at their burial at which a eulogy or a favorite song of the deceased often represents the grieving sentiments of survivors.

Mario Erasmo

See also Christian Beliefs and Traditions; Elegy; Funerals; Hindu Beliefs and Traditions; Jewish Beliefs and Traditions

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Language of Death

The language of death involves strategies of avoidance or consolation when naming death or speaking about a decedent; it is the use of euphemisms or linguistic tools to soften people's reactions to death and dying. The concept is not to be confounded with *language death*, which is a term used by linguists to describe the disappearance of languages as a result of colonialism, assimilation, government policy, or other social or natural forces. Language, the result of the social need for communication, was initially conceived to name objects from the near environment but has evolved into a complex system, capable of referring to abstract concepts and multiple meanings, including the semantic field of death. The language of death reflects the cultural attitudes toward this event. In modern societies it is used not merely to inform, represent, and reflect upon death and dying, but also to aid in epidemiological, medical, and legal discourses on decedents and their survivors.

Emergence of the Concept

Studies on Euphemisms

Questioning about death and beyond has been an ontological matter that goes back to the origins of mankind; however, there was little scientific concern about it up to the past century. As early as 1936, Louise Pound began reflecting upon American euphemisms for *dying, death,* and *burial,* but it is only more recently that scholars in the field of human sciences have begun researching how language is appropriated in communications about death and dying.

Subsequently, scholars point out that in the mid-19th century a shift in the conceptualization

of death occurred. Prior to the Romantic period, the language of death was replete with expressions such as *to pass over, to go home, to (be carried to) rest, to fall asleep*. These expressions were intended to help survivors cope with their loss, or rather the event of death itself. According to the anthropological point of view, death is a timeless taboo, the naming of which usually calls up superstition of contamination from the concept to the object. This is useful to explain the universal use of metaphors, euphemisms, and slang to represent *death, dying, the deceased,* and *burial*. The use of metaphor is pervasive, as shown in studies on primitive societies. Besides, in civilizations with written traditions, while literary works never really considered the moral interdiction, the language of death continued to flourish, and a rich semantic field developed around the typology of death.

Nowadays, the language of death is expressed through the vernacular, but also the religious, the medical, the legal, and other scientific terminologies (demography, sociology, etc.). Most of them have euphemistic ground: For example, *cemetery* comes from the Greek word for "dormitory," *euthanasia* from "good death," and *casualty* meant "accidental loss" up to the Crimean War. The study of etymology also shows that the use of metaphors has a long tradition in the reference to death and the technical concepts inherited from it. In some cases, the linguistic turns soften the approach to death, whereas in others they bring forth value interpretation (e.g., *suicide vs. autolysis, euthanasia vs. well dying*). Contemporary concern is to avoid social stigma and moral judgment; thus the language of death is contextually dependent.

Linguistic Taboo and the Cultural Paradoxes

In modern societies, scientific progress moves the dying from their homes to medical institutions with the consequence of excluding them from their familiar surroundings and daily conversations. Thus, death returned to being a linguistic taboo. Later, the industry of preprinted condolences developed stereotyped all-inclusive formulas to express personal messages of sorrow while mourning the dead.

In 1969, scholars began writing on the importance of finding a place for the dead among the living in order to fight over these attitudes of disinterest. In practice, since the late 1990s, *Vivre son deuil* (Living With Mourning), a European organization, has encouraged survivors to speak about their grief in order to free their phantasms and fears about the life beyond. Hope and consolation are gently encouraged.

Current Attitudes of Survivors

The language of death offers a way to think about and to discuss death that is reflective of the extant cultural attitudes that surround end-of-life processes, as well as representations of grief and mourning. Since the end of World War II, on both sides of the Atlantic, humanitarian organizations have been struggling to defend civil rights by using correct language with respect to death. According to the experience of volunteers, silence can be encouraged as a humble attitude of respect for the loss of the decedent's survivors and as a protection against stereotyped formulas. Thus, traditional and psychological models of bereavement highlight the emotional aspect in the process of recovery. Sometimes neglected in modern societies, rituals also reflect cultural and linguistic patterns about death.

Additionally, Ruth Menahem argued that language was a medium for impulsive representations to express themselves, so that unconscious desire might accede to the conscious mind. However, there is no language without desire, and the only desire that all humans accomplish is their wish to die. Thus the study of language is helpful. It is a means to understand human attitudes toward death.

Speaking of Death in a "Proper" Manner

In many cultures, the language of death is constantly revised and adapted to social realities. The medicalization of dying, in its conception of death more as a process than as an event, rendered the subject of death elusive and even obscene to the common man.

There exists a schism between the effort to humanize medical language and the scientific need to be more explicit and less ambiguous about death and grief. In the latter instance, common expressions are misleading, especially among children who remain confused in the hope that the "departed" may come back. Most adults in turn

consider that the way in which they are informed about the death of their beloved ones has a great impact on the entire process of mourning and recovering. Doctors and policemen are therefore trained to adopt an allusive approach to informing about death rather than a direct one. All in all, the word *death* evokes strong emotions, but it seldom allows a satisfactory alternative.

The language of death is crucial for professionals and volunteers who deal with grief, mourning, and bereavement. However, a rigid labeling of the steps involved after a loss induces the risk of "iatrogenic injury" (injury contracted inside the medical institution). An appropriate discourse on death can help survivors recover from their loss. Professional language itself is submitted to this social norm, especially with regard to critical terms such as *euthanasia, physician-assisted suicide,* and *murder.* Accordingly, it is recommended that physicians should use a specific form of language when speaking with peers and another, more vernacular form when addressing families. If guilt and social stigma are to be avoided, the use of appropriate words becomes a crucial aspect of medical management.

A Humanistic Approach

In modern societies, the professional and profane are no longer separate; thus, language generally suits the psychological needs of speakers. Rewording is required in order to adapt scientific terms to the reality of the human condition. The French thanatoanthropologist Louis-Vincent Thomas wrote about the important use of appropriate terminology when death by suicide is involved, noting that the general discourse about suicide is linguistically aggressive. Words constructed with the root *cide*, from the Latin *caedere* meaning to kill, are linked to the idea of interpersonal violence (*fratricide, genocide, homicide, matricide, parricide*) and therefore easily attached to sin and guilt. That is why the English language, through the Oregon Death with Dignity Act of 1994 and the California Compassionate Choices Act of 2007, offers such expressions as *aid in dying, choice in dying,* and *end-of-life choices* as preferred to *assisted suicide.* These linguistic turns are meant to protect the medical staff and patients either from accusation of unkindness or from stigma associated with the use of the word *suicide*.

Legal Responsibilities

For a long time, technical terms were employed alongside vernacular ones in the scholarly literature on the language of death. Euphemisms arose, particularly in the medical realm, but more concrete terms were needed for legal purposes. Current studies suggest that because legal decisions are influenced by clinical language, it may be necessary to more clearly designate the clinical process of death.

For instance, after the attacks of September 11, 2001, the New York City Office of Chief Medical Examiner considered that the deaths of people jumping from the World Trade Center towers should be recorded as homicides and not suicides. In 2005, a Gallup survey showed that 75% of the people interviewed were favorable to the "end-of-life" decision, but only 58% accepted the idea of "assisted suicide." In this context, causes of death as recorded in medical certificates have a determinant influence on decisions insurance companies make regarding payment of policies and sometimes on what sort of religious sermons are given at funerals.

Suicide: A Controversial Concept

The contemporary preoccupation with suicide as a major problem of public health, as well as the means to prevent it, led to the development of a language of suicide, which includes transparent terms that contain no subjective judgment. Suicide is still depicted as a sin, a crime, and as proof of alienation. The existing language surrounding suicide is therefore marked with social stigma or legal sanction even where legal institutions, insurance companies, and churches have reformed their attitudes toward this kind of death.

According to the French Ph.D. Pierre Satet, confusion may come, on one hand, from mass media reporting differently the death of a celebrity and that of a noncelebrity. Constrained by economic and commercial interests, newspapers give more space in their columns for the former. Paraphrases such as "to put an end to one's days" are therefore more likely to appear with reference to a film or rock star, for example, while the word *suicide* is more often used with reference to common people. On the other hand, there is little consensus among medical staff, who may use *suicide* and *autolysis*

interchangeably even though these words do not refer to the same clinical phenomenon. However, Satet thinks that the most inappropriate use is *recidivism* for repetitive suicide attempts: Coming from legal terminology, this word is defined in dictionaries as the commitment of a new crime once the person has already been condemned.

In this context, one of the aims of the regional programs of health is to try to change society's perception of suicide. Consequently, Satet proposes to replace the word *autolysis* by *suicide, recidivism* by *repetition, recidivist* by *primo-* or *multi-suicidant,* and so forth.

The general conviction is indeed, as the writer Albert Camus put it, that to name things improperly is to add to the misery of the world.

Cristina Dumitru-Lahaye

See also End-of-Life Decision Making; Epitaphs; Literary Depictions of Death; Symbols of Death and *Memento Mori*; Tombs and Mausoleums

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Last Judgment, The

The Last Judgment, or Day of Judgment, is a theological belief that refers to the last day of earth's history in which the faith and "faith enacted" of every person who has ever lived is reviewed by God. While all of the main world religions have this concept embedded in their religious belief systems to some degree, it is in the theological texts, statements of beliefs and liturgies of Christianity, Judaism, and Islam that this concept is most clearly delineated. Despite the differences in beliefs, outlooks, or conception, the unifying understanding is that this is the time when God, the initial creator being, completes the cycle of humanity's history by finalizing or doing away with the issue of sin and its linked consequence of death, and commences or creates a new earthly form of paradise.

Despite the large range of differences in theological perspectives, there are a number of similar concepts and understandings that underpin the various belief structures of the Last Judgment. While not inferring there is unity of belief among the commonalities of focus with regard to this area, the one persistent common denominator is the notion that death for believers is no longer a factor in their continuing existence. Thus, this entry uses the notion of death as a means to delineate the foundational elements that relate to the Last Judgment as a holistic uniting perspective.

Concepts of Language, Death, and Judgment

For the majority of the world's great religions, the texts that detail and describe the Last Judgment are couched in a genre and associated language use that is typically eschatological (deals with the times of the end) and in many cases apocalyptic (deals with God interceding directly into the affairs and time of humanity). The language use of these texts is one typified by symbols and metaphors as seen in the Christian books of Revelation and Daniel. While there are various forms of exegesis related to apocalyptic literature across the religious belief systems, it is generally accepted that despite the difficulty in understanding the precise meanings of these symbolic forms, when it comes to the associated meanings of death in these texts, the meaning and implications are much clearer. The overall

language use is intended to reveal the devastating effects that God has on unbelievers when He directly steps into the human world to execute final judgment. In a general sense, the Day of Judgment for believers represents a final and everlasting release from death, whereas for unbelievers it represents a total and eternal separation from God through a perpetual death or a life in hell, or Hades. An example of this release from death is found in the second chapter of the Christian book of Revelation in which believers are said to not suffer "the second death," which is a reference to being vindicated or redeemed in the Last Day Judgment. The sense of being separated from God, or suffering the "second death," is found in chapter 4 of the same text in the symbolic entrance of the Four Riders of the Apocalypse. Both of these motifs are also found as reoccurring themes in the last five chapters of Daniel, an apocalyptic and eschatological text (in the Old Testament Christian canon) held as the epitome of overcoming the curse of death and evil for both Jews and Christians.

A similar set of eschatological motifs are also found in the Qur'an. For Muslims, the Final Judgment involves each person being handed a "book of their deeds," which lists and details all of their thoughts, actions, and utterances (Qur'an 54.52–53). Using a similar metaphor as found in the Christian canon, if believers are given the list of deeds in their right hand, they lose the possibility of death forever and enter the gates of paradise. However, if handed over to their left, they forfeit a life of pleasure and suffer the "living-death" sentence and enter hell.

Concepts of Atonement, Death, and Judgment

As one of the key metaphoric threads that run through the religious texts of Islam, Christianity, and Judaism, and in particular the apocalyptic texts, is the concept of atonement. Literally meaning "at one with God," while prominent in Judaism and Christian thinking and belief structures, it is held within Islam as a ceremonial reminder of Mohammed's tripartite role of prophet, priest, and wandering leader through a series of rituals. The unifying narrative in all three religions that clearly highlights the Judeo-Christian tradition of needing an intercessory sacrifice, and reveals Islam's link to its ideals of priesthood, is the story in which God calls Abraham to sacrifice his only son, Isaac. However, in this narrative just as Abraham is about to kill his son God intercedes by providing a ram caught in a thicket. The Judeo-Christian belief structure believes this is a metaphor for humanity's need of priest-intercessor to act as a substitutionary death as the human condition alone falls short of the requirements to enter heaven. In Islam this intercessory death narrative is reiterated through the Feast of Sacrifice, held simultaneously across the Muslim world, which celebrates the Abrahamic atonement sacrifice as a symbol by which Mohammed celebrated the unifying conquest of this new religious faith over an older form. While there are obvious differences in perspectives among these religions, the atonement metaphor can also be seen to represent a restructuring of a new world and a new life in which death has been eliminated. This atonement process also entails the setting up of the universal sovereignty of God and the establishment of a reign under which God's enemies are finally destroyed and God's people are converted and gathered into a redeemed land or universe. Through the ending of death, the final kingdom of God is given life.

Another link to the atonement concept is the Judaic festival of Yom Kippur, a festival that symbolizes the ultimate death of sin. Held at the end of the Jewish year, it is also symbolic of the Last Judgment in that in the original sacrificial mode, the accumulated sins of the entire Jewish nation were figuratively placed onto a "scapegoat" representing Satan and then sent into the desert to die. Thus, sin was metaphorically killed forever, leading to the Last Judgment in which atonement would reach actuality. For many Christian denominations, this notion of Yom Kippur has a twofold application in that Christ became the scapegoat and through his own death he vicariously carried the sins of the world into nonexistence. At the end of days, or the Last Judgment, this sin burden will be placed on Satan, the instigator of this problem, who once and for all carries the sins he is ultimately responsible for into final oblivion, namely, the depths of Hades. Thus, death will no longer exist in God's universe.

It is at this point that one of the critical elements related to death, the concept of time, is also finished. Generally considered to be one of the key fears of all humanity, as each day brings the living

human one day closer to the ultimate fear, death itself, it is at the Last Judgment that eternity commences for those redeemed from the curse of sin. The concept of immortality ushered in by the completion of the Last Judgment is not only characterized by a rejoicing as the redeemed finally enter paradise, but the tyranny of time, which has a constant earthly focus of impending demise, is also considered by many religious texts to be a key facet of this happiness. Thus, not only are the saved made *at one with* God, but the three elemental facets of the universe—time, space, and matter—are also freed from the connection with death.

Concepts of Messiah, Death, and Judgment

One of the commonalities found in world religions and how they view the concept of the Last Judgment is the need for a messianic figure to return to the earth to either usher in the period of the Last Judgment or execute the actual judgment process. Notwithstanding the variations of belief in this regard between Qur'anic, Old Testament, and New Testament scholars, there are also a number of various understandings within each of these belief systems. However, in summarizing and synthesizing these variations, in each perspective the Last Judgment is typified by a resurrection of the dead to face judgment either for the deeds or faith. This resurrection typically takes place immediately before or with the simultaneous appearance of the Messiah. For Christians, the Second Coming of Jesus initiates this reappearing of the deceased in tandem with the complete destruction of the earth and, as stated previously, commences the Last Judgment. Islamic scholars also generally believe that the Last Judgment will be characterized by the death of all creatures, an earthly devastation process, and Second Coming of Christ. However, in Islamic eschatology the Second Coming of Jesus in itself precedes the coming of the true Messiah, the *Mahdi*, or the one who comforts, guides and protects. The Mahdi then unites all Islam and defeats the enemies of this now united force.

Critical Concepts of Death and Judgment

This discussion revolves around several key facets of current theological debate and investigation. The first is the notion of what actually happens at the point of death. The traditional Christian belief is that the living body has a separate and distinct "soul" component that departs at the point of death to enter into an initial judgment determining an ongoing existence in heaven or hell. However, new etymological Old Testament research now suggests that perhaps the original Hebrew word details the body as "being" a living soul. In concert with several verses of the Old Testament and a few key points of theology from the writings of the gospel author Paul, it would appear that alternate view of the death-soul relationship exists. This alternate theological point suggests that when death occurs, the body as an entire physical-spiritual entity dies and awaits a final resurrection.

Logic would then suggest that the believer is not fully redeemed until death is finally decreed to be eradicated by God at the Last Judgment. This is perhaps the actual meaning of *the second death* in that believers enter eternal life at the Last Judgment, and nonbelievers suffer eternal separation from God or actually die an "eternal death."

Another key theological aspect that is yet unresolved in Christianity is the concept of the millennium, or the period that is often determined to be 1,000 years of peace that occurs either before the coming of the Messiah or after his appearance. While this may appear to be a side issue, this focus has been recently recognized as a critical factor related to the notion of death in that questions are being asked as to what actually happens at death, and between death and the resurrection. There is also a growing theological perspective that aligns itself with the Islamic view that the millennial period occurs prior to the arrival of the messianic figurehead, and this period is a one of worldwide destruction and disasters. In regard to the Last Judgment, the death of an individual and the death of the world appear to be intertwined.

Phil Fitzsimmons

See also Apocalypse; Armageddon; Christian Beliefs and Traditions; Eschatology; Hell; Resurrection

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Last Will and Testament

A last will and testament is a document that describes how a person desires to have his or her property distributed after death, who that person wants to be in charge of settling his or her estate, and who he or she nominates to raise underage children. Usually this document is written by an attorney to ensure it meets the legal requirements of the state where the person lives. However, it can be handwritten or created using outlines in kits that can be purchased commercially. The document should be signed in the presence of witnesses who will not benefit from it and who can verify the signatures.

AARP (formerly known as the American Association of Retired Persons) researchers report that only 60% of Americans over the age of 50 have a will, and even fewer under that age have one. Most people do not like to think about tasks such as writing a will. However, having a plan for one's death, whether or not death is expected, can prevent many family-related problems. Making a will is one way to care for people who are important in one's life. When one's desires are specified and what may be perceived as apparent inequities are explained, there are likely to be fewer disputes and other types of problems after death. Having a will can also save money, and when life events bring about change, a will can be modified.

Today the term *will* is typically used whereas in the past, many people referred to this document as a "last will and testament." Technically, the testament refers to personal property, but today people seldom use this term.

Why a Person Should Have a Will

Anyone who is 18 years old or older and who has a "sound mind" can make a will. A will gives greater assurance that dependents will be taken care of and that property will be distributed as desired. A lawyer should help phrase it in the appropriate legal terms so that it will be read by the probate court as the person it is written for intended it to be interpreted.

A will can provide for equitable treatment of children. That does not mean each child necessarily gets exactly the same things. It is possible to provide for special needs and explain intentions in a will. Moreover, one can nominate a guardian for minor children in the will. Although the court must appoint the guardian, by creating a will parents can establish who they desire to raise their children.

A will can also be used to nominate the executor of the estate, or the person who will settle the specifics of the estate. Again, only the court can appoint the executor, but if the person nominated meets the state requirements and is willing to serve in this capacity, then the court will likely appoint the person nominated. Through a will, a person can specify that his or her personal representative serve without bond or surety. If bond is not required, then the administrative cost of settling an estate is considerably reduced.

A will should simplify the distribution of property and thus shorten the time required to settle an estate. If a person dies without a will, which is called dying intestate, then state law in effect at the time of death will specify how property will be distributed. Thus, everyone has a plan even if this plan does not represent the desire of the deceased. For example, state law often specifies that when a parent dies without having a will, the surviving parent will receive a third of the estate; the children will share the remainder. The surviving parent will have to regularly prove to the court that he or she is managing the minor children's assets appropriately. But a will can specify that the surviving spouse will receive the entire estate without requiring proof that financial decisions are made in the children's best interests. Finally, a will can provide for the full distribution of assets in case of simultaneous death of an entire family through a common event.

When a person without a spouse or children dies, state law might specify that the estate be split

equally among the deceased's siblings. The state's plan for assets will not direct any of them to a favorite charity or someone who was important in the life of the person who died but was not related by blood or marriage.

Major Components of a Will

There are three primary requirements: First, the provisions of the will must express testamentary intent (the person's intent to make a will) and the contents only become effective at the testator's (the person's) death. Second, the will must be in writing (no verbal wills are valid), dated, and properly signed by the testator (the person). Finally, the testator's signature must be witnessed by at least two, preferably three, competent witnesses. These should be people who will not benefit from the will and who are younger than the person so that they are likely to be available when needed. They must sign the will at the testator's specific request and should also sign the will in each other's presence. This will prevent the necessity of proving that their signatures are valid when the will is probated.

A will can be changed by a codicil, which is executed in the same manner in which a will is executed. It can remove, change, or add sections to the original will. Execution of a later will voids all previously made wills. Thus, a lawyer's help is recommended in writing a will so that it meets the state's legal requirements for transferring property.

Process of Creating a Will

Although the procedure is not complex, the creation of a will requires one to do the following:

- List all real and personal property, indicating how the property is owned. In the case of joint tenancy with right of survivorship, the property automatically goes to the other owner(s) when one dies and thus is not affected by a will.
- Indicate how the property should be distributed, especially property with large financial value. Instead of listing every item of property in the will itself, a person may chose to attach a list that specifies what happens with each item. Explanations are not required for these decisions but, in some cases, it is helpful to provide information about the property.
- Nominate an executor for the estate, the person who will settle the estate. Some states have specific requirements for this person, such as the requirement that the executor reside in the state where the estate is being settled. The will may designate the representative be compensated, either financially or with items.
- For those who have minor children it is important to nominate a guardian(s) who will assume the responsibility for raising the children should the parent die prior to the legal age by which adult is defined.
- Get a lawyer to draw up a will so that it is written in the legal terms that allow the probate court to ensure desires are fulfilled.
- Have two or three copies of the will made. Sign one copy of the will in the presence of at least two, preferably three, witnesses who are not named in the will and who will not benefit from it. They will also sign it. After the death of the person who writes a will, the court will ask them to verify the signature on the will and to avow that the person who signed it appeared to be mentally fit and was not forced to sign the will.
- Keep the will in a safe place. Many people place a signed copy in a bank safety deposit box, request their lawyer keep a copy, keep a copy at home, and perhaps give a copy to the person nominated as personal representative. In some states, bank safety deposit boxes are sealed at a person's death and their contents cannot be accessed until a personal representative is approved by the court to settle the estate. Thus, it is important to understand the applicable state's laws concerning this issue. A will should be placed where it will not be damaged or discarded. The will should be kept in a place where it can be readily found when needed.
- Periodically review the will to see if changes are needed. Over time situations change as people marry, divorce, or die, and as new family members are born. It is particularly important to have the will reviewed if one moves to another state. It is also important to recognize that the way that title is held on property takes precedence over a will.

The Standard Form

Standard forms for creating a will are available in bookstores and other readily available venues.

These may provide a format for a will and help one identify all the information that is needed in a valid will. State law has the most influence on the issues that are addressed by wills. Although an attorney will create a will based on the client's desires, most state legislatures reevaluate estate law on a regular basis. For this reason a will should be periodically checked by a lawyer to ensure the document is in conformity with state requirements.

Letter of Last Instructions

Placed in a sealed envelope marked "Letter of last instructions, to be opened after my death" and followed by a signature, the letter of last instructions is an important document. Although many people believe that information pertaining to burial and memorials is included in a will, it should instead be in a letter of last instructions that will be read immediately upon death. Whereas the will generally is read after burial or a memorial service is conducted, a letter of last instructions is appropriate for specifying requests for burial and memorials. Such letters may be very specific, including, for example, selections of music and readings, or the instructions may be of a more general nature.

Increasingly people are making plans with a funeral home, and such plans should be made readily available. Thus, including such information in the letter of last instructions will allow family and friends to proceed with the necessary arrangements following death. This letter can also direct the appropriate people to the location of the will and to those who have a copy of the will.

Irene E. Leech

See also Estate Planning; Inheritance; Legalities of Death; Memorials; Pre-Need Arrangements

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Legalities of Death

Laws change with the times; they attempt to catch up with technology, reconcile nondominant cultural beliefs and morals with the dominant paradigm, and find better ways to protect and control society. Laws, rules of conduct, ethics, religious beliefs, societal norms, cultural morality and expectations, community values, and personal meaning and attitudes all combine to work together to form a labyrinth of confusing and conflicting legalities. These rules and laws govern death in our lives from before conception to after death. Cultural beliefs, rules and laws intersect and modify, add, limit, protect, or confuse the issue at hand. There is no set rule, law, ethical position, or constant to assist in determining what the legalities of death are.

At the beginning of the 20th century, however, most people died at home, and the laws and rules of death were simpler and more attuned to the local cultures and customs. At the beginning of the 21st century, most people in North America die away from home, in hospitals and institutions. As living and dying have become much more complex in North American society, so have the laws and legalities of death.

Technology has surpassed our ability to develop legal rules to set standards governing death. It is difficult for anyone to die, in the normal course of events, without specific decisions being made to withhold or to withdraw medical treatment. Medical technology has trumped culture. The conflicting interests of specific cultures, family, community, and society at large—coupled with a general lack of knowledge of the laws relating to

death, and thus a lack of preparation for death—create a miasma around personal choice in death.

Technology allows babies, who in previous times would have died, to be born and to live long lives; technology can extend the *life* of a person for years beyond what the body alone could do. Definitions of death are no longer valid in the face of modern technology; a body does not have to live on its own. The law does not consistently inform as to who has the right to say when technology is to be released and to rely solely on the strength of the body to determine when death comes.

Definition of Death

The U.S. Federal Uniform Determination of Death Act provides two criteria for determining death: (1) irreversible cessation of circulatory and respiratory functions or (2) irreversible cessation of all functions of the entire brain including the brain stem. The ordinary definition of death is the permanent cessation of functioning of the organism as a whole. However, these definitions often do not provide the necessary explanation of death, and there exists still today legal, medical, ethical, moral, and religious debates over exactly when a person is dead. Sometimes the decision is made by the courts. Terri Schiavo, a married woman in Florida, who was in a persistent vegetative state and living on medical devices, was the subject of a court case, indeed a national debate, between the husband and the woman's parents, as to whether the medical devices should be shut down. The local court allowed the husband to make the decision to remove the medical devices that kept her breathing and her heart working and the woman died. Several states away and months later another woman was in a similar state. This time the parents of the woman and the husband agreed that the medical devices being used to keep their loved one alive were to be disconnected. The woman woke up and lives.

The "brain death" definition arose in the 1960s and 1970s as technology allowed the intensive care unit to become a surrogate for the brain stem to keep the heart and lungs functioning. For organ transplants, this definition of death, along with very advanced medical technology, allows time for the doctors to remove the organs for donation. In rare cases modern technology allows a fetus in a dead mother to proceed to term. If the brain is dead but the body is breathing and the heart beating, when do the doctors remove the functioning organs? Indeed, when is the body buried or cremated if cardiorespiratory functions are still active? Who will disconnect the medical devices?

When Does Life Begin?

The opposite end of the continuum brings even more legal complexities. The rule of law does not always control or satisfy the beliefs and rules of the various segments of society. The issue as to the moment life begins is argued vehemently by many and diverse groups. Some religions argue it begins at the moment of conception. The Supreme Court of the United States allows a woman to abort a child for many months after the point of conception. It is a contradiction in law and the rules of society. An abortion is permitted by law, yet in some states it is a crime to use illegal drugs while pregnant. If one kills a pregnant woman, the court may charge two murders. There is no one law or standard that declares when a forming fetus becomes a *life* and therefore has the right to the protection of the law. The law has much difficulty with the rights of a woman and the timing for the beginning of the rights of an unborn child. In this most contentious of debates, there is no satisfactory middle ground. The rules of secular law and religious belief can often collide with such a force, crushing any possible reasoned review of each individual case.

The Killing of Another

Both secular and religious laws prohibit the killing of another. The law makes certain exceptions: self-defense, defense of another, war, and the death penalty. Laws limit how each of these exceptions functions. Many jurisdictions do not allow the death penalty, and the rules of war must be obeyed to maintain the protection of the law. The use of deadly force in self-defense and in defense of another is strict and limited. The law recognizes degrees of culpability in the death of another, from negligence or wrongful death, to manslaughter, to the intentional killing of another. Penalties for wrongful killing range from civil monetary damages, to imprisonment, to death.

Wills, Trusts, and Probate

Wealth can be a burden at the end of life—for the person dealing with impending death as well as for the survivors—if arrangements were not previously made for a will or to avoid probate. The fear of death seems to prevent people from looking at these difficult end-of-life decisions and drawing up a will or an advance directive for health care. Wills and trusts can define how property is to be dealt with after death. The law will limit, in certain cases, the ability of the decedent to keep property from certain classes of people, such as a spouse. The rules of probate and estates are complex and as demanding on the courts as on the families. Inheritance is a creature of the statutes of the jurisdiction where the death occurs or where the matter is probated. Probate is the legal process by which the distribution of property and the protection of minor children are determined, whether through a will or by the statutes of the jurisdiction if there is no will. Advance planning can avoid the morass and expense of the probate court through the manner in which title is held to assets or by creating trusts. Whatever the situation is, the law of the jurisdiction controls the division and distribution of property. These rules are not consistent in all states or provinces. The laws of inheritance are often not consistent with the culture and customs of groups not part of the dominant society. This can create additional burdens on the courts and families. In a nonhomogeneous society the laws and statutes set down by the dominant culture will often clash with the beliefs and customs of nondominant cultures.

Advance Directives

Often the family and friends of the dying person sit helplessly at the bedside unable to navigate or control the vast medical system. Doctors make decisions that are often in conflict with the wishes of the family. A doctor's training is to protect and prolong life. Yet there comes a time to let go and allow the person to die as peacefully as possible. There are times when it is not in the best interests of the dying person to be resuscitated and placed on medical machines to prolong life. Often the family and the doctor or medical practitioner can come to agreement as to the form of care to be given. However, when the dying person can no longer speak for him- or herself, it becomes the task of the family and the medical personnel to decide how best to proceed. In the United States competent persons can make their own decisions as to health care at the end of life. Under the Patient Self-Determination Act of 1990, competent persons can control their medical treatment and even write an advance directive telling family and medical staff how they wish to be cared for when they can no longer make their own decisions. All hospitals are required to obtain such a document.

This is a sensitive subject in our death-phobic society. How, when, and under what circumstances this advance directive form is to be obtained are difficult issues for most people. It is a conversation that needs to take place within a family at a time when there is not a crisis.

Right to Die

In the United States it is a constitutional right to make one's own decision regarding medical care and to refuse medical care even if it will result in an earlier death. However, there is no correlative right to die. The U.S. Supreme Court refused to rule on the issue of assisted suicide, or euthanasia, and left it up to the individual states to decide how to deal with these issues. Only Oregon has a law allowing, under strict guidelines, a doctor to provide lethal drugs to end one's life. All other countries, save the Netherlands, have made assisted suicide or euthanasia a criminal offense. However, while assisted suicide is technically illegal in the Netherlands, doctors often assist patients in assisted suicide without any criminal prosecution. There are linguistic differences between the terms *assisted suicide* and *euthanasia*, wherein the former is usually thought of as having the consent of the dying patient, and the latter without such specific consent. Euthanasia under all circumstances is considered murder, even in cases of true compassion.

Disposal of the Body

While the laws in each jurisdiction are different regarding the handling of a body after death, generally a body must be buried in a cemetery or an authorized burial site. Cremations must be done by a licensed facility. In many jurisdictions the ashes of the deceased may be disposed of at sea

(not at the shoreline) or on private property with the consent of the property owner. Often a body may be kept at home for a certain period of time before the cremation or burial. Home funerals are difficult but there is a movement in some states, such as California, where the family can create their own funeral; the technicalities of the paperwork, however, often defeats the grieving family.

The legalities of death are confusing, vague, and inconsistent. Each jurisdiction forms its own set of laws and statutes. The customs of each culture and religion added to that mix often form a wall against understanding and resolution. One answer to chaos at the time of death is early planning and conversations with family members about how we wish to die. Completion of an advance directive and a will to direct the family and the courts can ease the burden of dealing with the legalities of death at the end of life.

J. Earl Rogers

See also Abortion; Assisted Suicide; Last Will and Testament; Living Wills and Advance Directives; Right-to-Die Movement; Wrongful Death

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Life Cycle and Death

Death is an integral and inevitable component of the life cycle and can occur at all developmental stages. Children and young adults may die, and older adults must die. Death at varying stages of the life cycle presents unique developmental and psychosocial challenges for the dying person and for his or her family. Medical and technological advances over the past century have changed the manner of death as well as the process of dying, leading to an increase in death anxiety and increased burdens on family caregivers. During an often prolonged dying process, the dying person and family members grieve multiple losses, including roles, hopes and dreams, material and emotional support. Finding meaning at the end of life can lead to lessened psychological distress for both the dying patient and for the patient's loved ones.

In 1900 the leading causes of death were accidents and infectious illnesses, which resulted in a relatively rapid dying process. Death most often occurred at home with all family members as active participants in caring for the deceased. In contrast, by 2001, 9 of the 10 leading causes of death were from chronic diseases with long deteriorating declines. The prolonged experience of dying in this century has given rise to changes in how care is delivered and who shoulders the burden of extended caregiving. Further, advanced technologies are prolonging the lives of children with congenital anomalies and chronic diseases. It is important to recognize that while the final stage of death may occur in a hospital, much of the prolonged dying process takes place at home. The meaning of the death and the nature of the loss, then, vary depending on the phase of the family life cycle.

The Family Life Cycle

Development, growth, and change are lifelong processes occurring in a sociocultural context. The family is the primary social vehicle for transmitting cultural worldviews and values. The death of a family member impacts the entire family as a functional unit, because all family members are interconnected and interdependent.

The awareness of the inevitability of death creates anxiety, as humans are wired for self-preservation. A shared cultural worldview that imbues life with order and predictability and provides rules and standards for behavior by which individuals attain a sense of value and self-worth alleviates the unconscious terror of annihilation. The family, as the primary mediator of culture,

organizes around the roles and rituals that support a worldview that death occurs at the end of a long, productive, meaningful life. How death is anticipated and experienced and mourned by the individual and the family is largely a function of whether it is consistent with or challenges this cultural worldview. In general, unanticipated and "unscheduled" deaths, deaths due to violence, deaths associated with multiple losses or other major stressful events, or deaths resulting in the loss of ongoing social support, result in less successful adaptation for surviving family members.

Death During Childhood

More than 50,000 children die in the United States each year. The U.S. infant mortality rate is higher than that of most Western European countries. The main causes of death during the first year of life are congenital abnormalities and sudden infant death syndrome. After the first year, the main cause is accidents, followed by cancer. A child's sudden death presents obviously different challenges for the family than does death following a long illness.

Approximately 25,000 children die each year from extended chronic illnesses. Another 500,000 children live with chronic, life-threatening illnesses. At the same time as they are dying, they are also growing and developing. Thus, to understand death during childhood, one must understand basic processes of child development: physical, cognitive, emotional, social, and spiritual. Cognitively, children's understanding of death depends on their developmental level. It is generally agreed that toddlers have little cognitive understanding of death. By middle childhood, most children have developed a mature understanding of death that integrates the concepts of irreversibility, nonfunctionality, universality, and causality.

Just as children develop more complex understandings of concepts as they get older, their psychosocial needs also change and are impacted by the dying process. The infant or toddler who is gravely ill, frequently hospitalized and separated from caregivers, and undergoing repeated painful medical procedures may be challenged to develop a sense of trust in their world. Preschoolers may find their need for independence and exploration limited by little or no energy, physical symptoms, and parental overprotection. School-age children may struggle with feelings of inferiority and inadequacy as their disease limits their interactions with peers and ability to engage in normal activities. The challenge for the family is clear: To promote healthy psychosocial development, parents must provide a continued presence and familiar routines and encourage the growing child to invest in age-appropriate activities to the extent their illness allows.

Children nearing the end of life are often aware of their impending demise and may grieve the loss of function, their inability to participate in play or school, and their imminent loss of family and friends. They may worry about how the family will cope after their death. While parents may wish to protect their children from the knowledge of their deaths, children will appreciate the opportunity for discussion in language they can understand. They may express their concerns indirectly, through symbolic or expressive interactions such as drawings, play, music, or rituals—and caregivers should be attuned to these important forms of communication. Even young children can be helped to find meaning and purpose in their short life and to receive reassurance that they will not be forgotten.

Indeed, the death of a child is one of the most stressful events in the family life cycle. An untimely, "unscheduled" death, it challenges the cultural worldview that children will outlive their parents, that the parents' role is to keep their children safe from harm, and that parents will live on through their children. The death of a child represents the loss of hopes and dreams for the future, and it challenges the belief in the orderliness and predictability of the universe. It often produces a crisis of meaning, as parents struggle to reconstruct a family narrative and find renewed purpose in the face of overwhelming grief. Prolonged grieving is common, and other important family roles (marital, parenting surviving children) are affected.

Surviving siblings often suffer a double loss: the loss of their sibling and the loss of support and emotional availability of their parents, who are coping with their own grief. A young sibling, experiencing typical rivalry or jealousy, may have wished for their sibling's death. Death can be described as a natural part of the life cycle, and the sibling should be reassured that their wishing for harm cannot make it happen. Children tend to

take euphemisms such as "passed away" or "gone to sleep" literally. Experts have thus found it to be more beneficial and less confusing to use words such as *death* or *dying* when explaining death to a child. The death of a sibling in childhood is a risk factor for later psychological difficulties. Much depends on the ability of parents to put their own grief aside to meet their surviving children's developmental needs.

Death in Adolescence and Young Adulthood

Motor vehicle accidents are the most common cause of death in adolescence, followed by homicide and suicide, but more than 3,000 teenagers die annually from chronic illnesses such as cancer, heart disease, metabolic disorders, and congenital abnormalities. Adolescents have a cognitive understanding of death equivalent to that of adults. Like adults, they are able to engage in spiritual and existential questions. Physically and psychosocially, many developmental changes occur in the years from age 11 to age 20.

Puberty may be delayed as a result of chronic illness, and illness and its management may cause disfiguring physical changes that are horrifying to a young person preoccupied with body image. The gradual shifting of attachment from parents to peers, and a developing sense of autonomy, may be delayed. The developmental push toward independence conflicts with the need for care during terminal illness. The terminally ill adolescent and his or her family may never celebrate the developmental milestones of a high school prom or graduation, a driver's license, or financial autonomy.

As adolescents deal with the sequential losses associated with terminal illness, they confront the meaning of their life and their curtailed future. Issues of transcendence and legacy may be prominent in their thinking. While minors are not considered competent to make medical decisions and decisions regarding end-of-life care, adolescents who have been undergoing medical procedures for long periods of time are often very knowledgeable regarding treatment, survival odds, and end-of-life options. Medical decisions may be the only manner in which terminally ill adolescents can assert independence and autonomy. There is an emerging consensus among pediatric health professionals, psychologists, and ethicists that adolescents have the functional capacity to make binding medical decisions, including the decision to discontinue life-sustaining treatment. These difficult decisions should, of course, be negotiated in the family context.

Parents anticipating the death of a terminally ill adolescent have the opportunity to express unconditional love and to complete unfinished business. Parents grieving an adolescent's sudden death, whether by accident or intentional violence, have no way to prepare for the massive disruption to life as they know it. While most bereaved parents feel guilty, the guilt is magnified for parents whose children have died by suicide or homicide. A search for meaning in the death may yield no good answers. For suddenly bereaved parents and siblings, grief is more likely to be traumatic and complicated, marked by anxiety and other mental health symptoms as well as sadness.

Young adults who receive a diagnosis of a terminal illness often face a long, protracted dying trajectory because, paradoxically, apart from the terminal illness, they are in otherwise good health, and illness complications like kidney failure or pneumonia are less likely to prove fatal. At the time of life when they are beginning a career and a family, they must prepare to die. Feeling cheated of the opportunity to see their children grow, young parents are faced with concerns of how to provide security for their family and how to leave a legacy for their children.

The death of a young parent and spouse has reverberations throughout the family. Multiple losses are likely to be experienced due to the loss of income and its effects. Like the death of a child, the death of a young adult is perceived as "off-time," a violation of the expectations of an orderly and just universe. Research shows that younger widows experience a more complicated grief than do older widows, for whom spousal death is expected. The grieving spouse must assume the role of both mother and father and must respond to his or her child's needs. Children may be angry at being abandoned by the dead parent. They may fear for their surviving parent's safety, for if the surviving parent dies, they wonder, "Who will take care of me?" Children may have to take on adult responsibilities if the surviving parent is unable to do so and may be loath to share their grief with their surviving parent, not wanting to distress the parent

further. Arguably the single most important factor in determining the child's adjustment to the death of a parent is how well the surviving parent is able to function, provide consistency and stability, and meet the child's developmental needs. Memories of the deceased parent often provide comfort to the bereaved child for years.

The death of a young adult also affects that adult's parents, whose relationship with their child has evolved from caregiving and total responsibility to a partnership and friendship with a unique individual. Parents continue their bonds with their dead adult children throughout the parents' life span.

Death in Middle Age

The main cause of death in middle age is sudden death due to stroke or heart attack. Overall, death rates in middle age have declined, largely due to progress in cancer treatment and prevention, and health promotion. While sudden deaths have the obvious advantage of preventing family members from experiencing or witnessing a long, painful decline and deterioration, no time is afforded to the family for shifting roles, learning new and needed skills, or anticipatory grieving. There is no opportunity to heal family rifts or make adequate financial preparations.

Families face multiple challenges when death follows long-term chronic illness. Families have had to reorganize to maintain "normal" family functioning during the long haul of the illness. As the illness progresses, families must continually adapt and roles must shift. Jobs may be lost as family members assume more of the caregiving burden, and the financial strains on the family are vast as savings are depleted. The dying adult must cope with the realization that long-held life goals and dreams may never be realized and will struggle to find new meaning and purpose in a shortened life span with diminished physical capacity. Bereaved middle-aged spouses often experience health impairment; men demonstrate greater impairment than women, possibly mediated by a greater loss of social support for widowers.

Death in Older Adulthood

The death of an older adult can represent, at the same time, the death of an individual, a spouse, a parent, and a grandparent in a complex web of family relationships across the life cycle.

Death in old age is a normative event. Nearly three fourths of all deaths in the United States are of people older than 65; one third of those are older than 85. Older adults have witnessed their friends and relatives die, and they are more accepting of their own inevitable death. They do not report declines in emotional well-being. The developmental task of older adulthood is to achieve a sense of integrity: that one's life has had meaning and value. Death is not fearsome for most older adults; rather, anxiety is centered on the dying process. Dying adults fear a loss of autonomy, and they fear burdening their family. They do not want to die alone, or in pain, or without dignity.

Death in old age usually occurs as a result of chronic conditions. There is likely to be a long period of caregiving at home resulting in tremendous financial, physical, and emotional strain on old and frail spouses and adult children. Bereavement often occurs as a transition from extended caregiving, and death may ease the burden and be seen as a relief. When familial resources are depleted, the end of life may occur in a nursing home or hospital, particularly when the patient has Alzheimer's disease or some other cognitive disability. In this case, death has come not too soon but too late.

The pattern of bereavement following spousal loss is varied. In general, older widowers have greater health and mental health risks than do widows. However, what is most striking is how resilient many older adults are following the death of their spouse. In one study, over half the bereaved spouses showed low levels of distress in response to the loss.

The grief of adult children following the death of their elderly parent tends to be attenuated, particularly if the parent died in a nursing home or had extended cognitive decline. However, if the adult child was actively involved in caregiving, there may be more emotional upset and symbolic connection to the deceased parent. Because the death of an elderly person is to be expected, there is often little social and cultural support for an adult child's extended bereavement. For young children, the death of a grandparent is often the first experience with loss. Not knowing how one is "supposed" to feel or behave, the children will take their emotional and behavioral cues from the

adults in their social environment. And the cycle of life, death, and bereavement continues.

Conclusion

The management of physical and psychological pain and suffering are salient issues for dying persons throughout the life cycle. Suffering can be eased when dying is viewed as part of the life experience. With palliative care, many patients can die at home, surrounded by loved ones. However, patients and families will need extended financial, material, and emotional support as they negotiate the inevitable role changes and transitions associated with a prolonged dying process. When death comes suddenly, it is the survivors who are faced with irreversible change and will need support. Much of this support can be provided by nonprofessional community members, but health and mental health providers have always had an important role in caring for people in transition. Nowhere is this more critical than in the transition from life to death, and from relative to bereaved.

Bronna D. Romanoff and Caroline C. Smith

See also Adolescence and Death; Adulthood and Death; Aging, the Elderly, and Death; Bereavement, Grief, and Mourning; Childhood, Children, and Death

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Life Expectancy

Life expectancy for any given age may be defined as the average number of additional years of life persons of that age may expect to live, under the condition that the schedule of age-specific mortality rates prevails. Life expectancy is most frequently calculated and reported for persons at birth, that is, at age 0, but, as is shown in this entry, may be calculated for persons of any age. Information on the life expectancy for persons of a given age indicates how many years of life, on average, persons may expect to live if, during their lifetimes, they are subjected to the prevailing age-specific probabilities of dying.

Life Expectancy and the Life Table

Life expectancy is calculated via the life table, a mathematical table that presents the mortality experiences of a population. The life table dates to John Graunt (1620–1674). The life table starts with a population (a radix) of 100,000 at age 0; from each age to the next, the population is decremented according to age-specific mortality probabilities, until all members have died; the mortality schedule is fixed and does not change over the life of the population.

Table 1 is an abridged life table for U.S. females in the year of 2005, developed by the World Health Organization. Given the very different age-specific death rates and, therefore, age-specific probabilities of dying for females and males, life

tables are usually calculated separately for the two groups. Eight columns are shown in the table.

Column 1 refers to the age intervals of each group. The entries refer to the range of years between two birthdays. For example, the age group 5–9 refers to the 5-year interval between the 5th and the 10th birthdays.

Column 2 reports for each age group the age-specific death rates, designated as $_nM_x$. These are the only empirical data needed to build a life table.

Column 3 reports for each age group the probabilities of dying, designated as $_nq_x$. This is the most basic column of the life table; the probabilities are derived from the death rates in column 2. The column 3 data are the probabilities that persons who are alive at the beginning of an age interval will die during that age interval, before they reach the start of the next age interval.

Column 4 presents data on the number of people alive at the beginning of the age interval, designated as l_x. This column of data is calculated by subtracting the $_nd_x$ value (column 5) from the l_x value in the age interval immediately preceding the one being calculated.

Column 5 shows the number of people who die during a particular age interval, designated as $_nd_x$, and is determined by multiplying l_x by $_nq_x$.

Column 6 reports for each age interval the total number of years lived by all persons who enter that

Table 1 Abridged Life Table for Females, United States, 2005

(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*	*(7)*	*(8)*
Age Range	$_nM_x$	$_nq_x$	l_x	$_nd_x$	$_nL_x$	T_x	e_x
< 1	0.00591	0.00588	100000	588	99471	8006245	80.1
1–4	0.00025	0.00100	99412	100	397410	7906774	79.5
5–9	0.00013	0.00064	99313	64	496404	7509363	75.6
10–14	0.00015	0.00076	99249	75	496057	7012960	70.7
15–19	0.00038	0.00192	99174	191	495392	6516903	65.7
20–24	0.00045	0.00227	98983	225	494354	6021511	60.8
25–29	0.00052	0.00258	98758	254	493156	5527157	56.0
30–34	0.00071	0.00353	98504	347	491652	5034001	51.1
35–39	0.00112	0.00560	98157	550	489409	4542349	46.3
40–44	0.00175	0.00870	97607	849	485911	4052940	41.5
45–49	0.00256	0.01273	96758	1231	480710	3567029	36.9
50–54	0.00370	0.01834	95526	1752	473252	3086318	32.3
55–59	0.00578	0.02849	93774	2672	462193	2613066	27.9
60–64	0.00909	0.04446	91103	4050	445387	2150874	23.6
65–69	0.01432	0.06911	87052	6016	420222	1705487	19.6
70–74	0.02252	0.10658	81036	8637	383590	1285265	15.9
75–79	0.03614	0.16574	72400	11999	331999	901675	12.5
80–84	0.06037	0.26226	60400	15840	262400	569676	9.4
85–89	0.10002	0.40008	44560	17827	178231	307276	6.9
90–94	0.16442	0.55054	26732	14717	89510	129045	4.8
95–99	0.26812	0.69160	12015	8310	30992	39535	3.3

age interval while in the age interval. The ${}_nL_x$ values are roughly given by the formula, ${}_nL_x = (l_x - \frac{1}{2}\,{}_nd_x)\,(n)$.

Column 7 reports the total number of years lived by the population in that age interval and in all subsequent age intervals, and is designated as T_x. To determine the values of T_x for each age interval, one sums the ${}_nL_x$ from the oldest age backward.

Column 8 presents the average number of years of life remaining at the beginning of the age interval, designated as e_x, and calculated by dividing column 7 by column 4. These are the life expectancy data.

Usually life expectancy for any given age, e_x, is larger than e_{x+n}, since e_{x+n} refers to additional life to be lived after the years $x + n$ have already been lived. However, Nathan Keyfitz and Wilhelm Flieger have found that in many countries (particularly developing countries and some developed countries), it turns out that e_1 is sometimes larger than e_0; this was the case in the United States as recently as the 1970s, when for females e_0 was 74.8 and e_1 was 75.2; life expectancy data for females in Mexico for the same year were 63.6 for e_0 and 66.9 for e_1. These patterns indicate a relatively higher infant mortality rate; they imply that if an infant is strong enough to survive the first year of life, then the average remaining lifetime on his or her first birthday is greater by more years than it was at the time of birth.

Life Expectancy and the Demographic and Epidemiological Transitions

Walter Scheidel reports that life expectancy at birth in ancient populations was in the range of 20 years to 30 years. In contrast, data from the Population Reference Bureau indicate that in 2007 the life expectancy at birth in the world was around 66 for males and 70 for females.

A major explanation for changes over time in mortality has its origins in demographic transition theory, which proposes four stages of mortality and fertility decline that occur in the process of societal modernization. The first stage is the preindustrialization era, with high birth and death rates along with stable growth. With the onset of industrialization and modernization, the society transitions to lower death rates, especially lower infant and maternal mortality, but maintains higher birthrates, so that rapid population growth is the result. The third stage is one of decreasing population growth due to lower birth and death rates, which lead then to the final stage of low and stable population growth.

Life expectancy changes may also be explained in terms of epidemiological transition theory. This theory focuses on the society-wide decline of infectious disease and the rise of chronic degenerative causes of death. According to epidemiological transition theory, as postulated by Abdel R. Omran, there are three stages. The first is the age of pestilence and famine in which the primary causes of mortality are influenza, pneumonia, smallpox, tuberculosis, and other related diseases, with high infant and childhood mortality and life expectancy averaging between 20 and 40 years. The second is the age of receding pandemics in which there is a decline in mortality due to improved sanitation, increases in standards of living and public health, resulting in a steady increase in life expectancy to around 30 to 50 years. The third stage is known as the era of degenerative and man-made diseases (heart disease, cancer, and stroke), in which mortality declines are due to medical advances in the prevention and treatment of infectious diseases. Richard G. Rogers and Robert Hackenberg have identified a fourth "hybristic stage," in which mortality is heavily influenced by individual behavior or lifestyle choices, and deaths are due to social pathologies such as accidents, alcoholism, suicide and homicide, as well as lifestyle issues such as smoking and diet.

Life Expectancy in the Contemporary World

Population Reference Bureau data indicate that in 2007 life expectation at birth in the world was 66 for males and 70 for females. In more-developed countries it was 73 and 80, and in less-developed countries (excluding China), 62 and 65. The highest life expectation at birth was in Japan (79 for males and 86 for females); the lowest was in Botswana (35 for males, 33 for females) and Swaziland (33 for males, 34 for females).

In general, the higher the country's level of economic development is, the higher its life expectation is for both males and females. The primary causes of death in more-developed countries are

heart disease and cancer, whereas in less-developed countries infant mortality and HIV are the leading causes of death. For example, Population Reference Bureau data for 2007 indicate that the infant mortality rate in Botswana was 56, in Lesotho 91, and in Swaziland 73, compared to less than 3 in Japan and Sweden. The percentage of people living with HIV between the ages of 15 and 49 in these countries is among the highest in the world. In 2007, the percentage in Botswana was 24.1, in Lesotho 23.2, and in Swaziland 25.9, whereas in Japan it was less than 0.1%.

Life Expectancy Differences by Sex

In more-developed countries, life expectancy at birth for females is approximately 5 to 7 years more than for males. This difference is attributed largely to biological and hormonal advantages that function as protective factors in women's health. However, this benefit is not always found for women in less-developed countries. For example, life expectancy in 2007 for males in Japan was 79 and 86 for females; in the United States it was 75 and 80, and in Western Europe, 77 and 83. In less-developed countries like Afghanistan, life expectancy is equal for both sexes: 42 years. In Botswana, life expectancy for women is in fact lower than for males (35 for males, 33 for females). Women in less-developed countries tend to have lower education and social status than males; these social disadvantages tend to obstruct the natural biological advantage that women have over men in life expectancy.

Life Expectancy Differences by Race and Minority Status

There are also life expectancy differences among racial and minority populations. In 2003, the life expectancy advantage for white females over black females in the United States was 4.4 years, and the advantage for white males over black males was 6.3 years. The racial differential in mortality in the United States has been studied and analyzed by medical and social scientists for many decades, but the differences have remained. A major reason for the racial differential is attributed to the socioeconomic consequences of lifelong poverty and experiences of racial discrimination, which limit the potential quantity and quality of health care available.

The Hispanic Paradox

Of particular interest in any analysis of majority–minority group differences in life expectancy is the consistent finding by Richard Rogers and his colleagues that Mexican Americans in the United States have an expectancy similar to, and sometimes higher than, Anglos (i.e., white non-Hispanics). Thus despite the fact that Mexican Americans and African Americans have higher rates of poverty and unemployment than do Anglos, and have also experienced more discrimination from the majority, Mexican Americans compared to Anglos are not disadvantaged with regard to life expectancy and other measures of longevity, but African Americans are. Several hypotheses have been offered to account for the Hispanic paradox and may be subsumed into three groups: data artifacts, migration effects, and cultural effects.

Life Expectancy in the Future

High levels of life expectation have been reached in this new century by many of the countries of the developed world. At issue is the likelihood that mortality rates will continue to fall, resulting in even higher levels of life expectation than those already attained. There are two positions: One argues for a limit and the other against.

An upper limit to human life expectancy is noted by James Fries, who predicted in 1980 that humans have a maximum potential life expectancy averaging about 85 years. Jay Olshansky and Bruce Carnes agree, noting also that all living organisms are subjected to a biological warranty period. If it is possible for humans to live to 100, people beyond age 80 should not be showing functional decline. But the data show substantial decline by age 80. Thus they contend that human life expectancy in the United States is not likely to exceed 90 years at any time in this century.

The major proponents on the other side, proclaiming the possibility of future and continued mortality declines, are James Carey and James Vaupel. They note that every time a maximum life expectancy number is published, it is soon surpassed. They also note that death rates in human and many nonhuman populations do not continue

to increase with increasing age, but there is a slowing or deceleration of mortality at the oldest ages.

Many of the developing countries still have high rates of infant mortality and general mortality. Infectious diseases remain a dominant cause of death in many of these countries. Modern medical and public health techniques will surely bring about further reductions in mortality from these causes, leading to declines in mortality in many countries.

Degenerative diseases are the major causes of death in the developed world. It is expected there will be future improvements in the treatment of these diseases in the next decades. However, only a basic breakthrough in the area of the physiological process of aging will increase substantially the length of time people in the developed world will live. Even the total elimination of a specific degenerative disease would not greatly increase life expectancy because, as Conrad Taeuber pointed out many years ago, if a cure is found for one degenerative disease, this will provide the opportunity for death to occur from another.

Dudley L. Poston Jr. and Eugenia Conde

See also Demographic Transition Model

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Life-Extending Technologies

See Life Support Systems and Life-Extending Technologies

Life Insurance

The first reference to life insurance comes from the Middle Ages. Groups of the poor in Rome came together to bury members and help their surviving family. It became popular in England in the 1600s. In France, life insurance was forbidden by the Marine Ordinance of 1681 on the basis that human life could not be valued or traded. In 1787 the King's Council authorized the first life insurance company in France.

The first company in the United States was formed in 1735 to help the families of Presbyterian ministers in Philadelphia and New York. The first companies were mutual companies, owned by the policy members. Later companies were publicly owned stock companies. The United States still has a mixture of the two types of companies.

In the United States, life insurance became popular in the 1840s when companies started to aggressively market life insurance policies. Since people did not want to place a dollar value on loved ones' lives, policies were used for commercial interests. Policies were first used by creditors on the lives of people who owed them money in the Northeast and in the South on the lives of slaves. In addition, slaves' lives were also insured by fire insurance as property. Business still uses life insurance to protect against the loss of key personnel and to allow a partner to buy out the family of a deceased partner. By 1860 the industry was marketing policies to protect the family if the primary breadwinner died.

Due to lavish spending and lobbying in the late 1800s at the expense of policyholders, New York legislature formed the Armstrong committee and in 1907 enacted strict guidelines for the investment

and use of life insurance premiums. This legislation was later adopted in many other states. With the passage of the War Risk Insurance Act in 1914 the U.S. government started to offer *term* and disability insurance. In April 1917, it provided $4,500 term life insurance to active duty personnel and sold additional insurance to families who wanted more coverage. When the service men and women returned home this type of policy declined in favor of *whole life* insurance. By the time of the Great Depression over 120 million policies were in force, the equivalent of one for every man, woman, and child in the United States at that time.

Although life insurance has many uses in both business and family life, the main purpose of life insurance for families is to replace lost income to the family when a family member dies during his or working years. It is also used to cover final medical bills, funeral expenses, and estate taxes for families that do not have other assets to cover these expenses. Life insurance policies can be used to ensure that child support or spousal maintenance payments continue even if the spouse making the payments dies. In recent years, a new issue with life insurance, the viatical insurance payment, has been tapping into the death benefit by critically ill patients while they are still alive.

Parties to Life Insurance

The insured is the person on whose life the policy is based. When the insured dies, the death benefit or face value is paid. The owner is the person who pays the premiums and has access to the cash value. The premium is the amount due the insurance company to pay for the life insurance policy. The beneficiary is the person or entity (such as a charity) that will receive the death benefit when the insured dies. A contingent beneficiary is the person or entity that will receive the death benefit if the primary beneficiary dies before the insured. The insurer is the insurance company that collects the premiums and pays the death benefit.

Types of Life Insurance Policies

There are three basic types of life insurance: term, whole life, and universal life. Term insurance is basic life insurance. It pays a death benefit to the beneficiary if the insured dies within the term of the policy. The term can be between 1 and 30 years. There is no cash value to this type of policy. For most types of term insurance policies, the premiums will increase each year.

Annual renewable term is a term policy that is renewed each year. The insured will only need to visit the doctor the first year, as the policy has a guaranteed renewable clause so that it can be renewed without proof of insurability if the owner wants to keep the policy for another year. Level term is a term policy under which the premium stays the same for the term of the policy. The premium is figured by taking an average of the premiums over the life of the policy. Group term is a policy that is purchased through or provided by one's employer, organization, or other group. The group is the owner of the policy, and the employee or member is the insured. This is the most inexpensive way to purchase life insurance but the insured may lose the coverage if the insured leaves the employer or the organization. Convertible term is a term policy that can be switched to a whole life or universal life policy at a later date. Perhaps the owner can only afford term insurance at the moment but is worried about the rising costs in later years. When the policy is converted, the owner locks in the premium.

Whole life insurance pays the death benefit as long as the premiums are paid, although some policies end at age 99. The amount of the death benefit cannot be changed. The premium remains constant for the life of the policy. Unlike term insurance, whole life insurance has a cash value account, or the saving component. The earnings on this account accumulate income tax free. The owner only gets the cash value if the policy is surrendered. The beneficiary gets the death benefit when the insured dies.

With each premium payment, the amount left after paying for the death benefit and administrative costs is held in an account, which pays either a fixed or variable return. The types of return depend on the type of policy. *Fixed* means the owner has a guaranteed rate. The insurance company chooses how the money is invested, usually in highly rated bonds and mortgages, and the rate will be based on current rates when the policy is purchased. *Variable* means there is a low guaranteed rate and if the company's investments do better than expected they will add additional income to the account for that period.

For a fee the owner can borrow against the cash value. Any unpaid loans will de deducted from the cash value, if the policy is surrendered, or from the death benefit, if the insured dies.

Universal life insurance is similar to, but more flexible than, whole life. It allows the owner to raise or lower the amount of life insurance as family needs change. With some policies the owner can pay one large amount and then future premiums are paid for out of the cash value. With other policies, the owner may have a minimum that has to be paid and an upper limit, which is the maximum the owner may choose to pay. This allows the owner to vary the premium rather than taking out a loan, saving fees and interest charges. There is also a loan option available to the owner.

Policies can have a fixed rate of return on the cash value or a variable rate of return. In addition, some policies allow a choice of investments offered by the company. This type of policy does not have a guaranteed amount, and the owner accepts all the risk for the investment decisions.

There are two types of universal life insurance. The level option works like whole life insurance, with either the cash value or the death benefit being paid but not both. The increasing option allows the beneficiaries to receive both the cash value and the death benefit.

Life Insurance Needs

The amount of life insurance needed depends on the expenses to be covered when the insured dies, such as debt, money for children's college expenses, child care costs, living costs for a spouse or minor children, final medical bills, funeral expenses, and estate taxes. However, a major consideration in how much life insurance to purchase is how much the owner can afford. While fully funding expenses makes life easier for the survivors, the owner needs to be able to comfortably pay the premiums to keep the policy coverage in force so that the money is available when the insured dies.

It is important to review life insurance polices whenever life events such as births, deaths, marriage, and divorce occur. These events may influence the amount of coverage needed as well as the choice of beneficiaries and contingent beneficiaries.

Payout Options

There are many different options beneficiaries can choose to receive the death benefit. The simplest payout option is a lump sum that pays beneficiaries the death benefit of the policy in one payment. They receive the money income tax free.

With the interest-only option, the death benefit is invested with the insurance company. Beneficiaries only receive the earnings. At some later date the death benefit is paid to the beneficiaries or contingent beneficiaries. The income is taxable as to the beneficiaries.

The other type of payout is an annuity, or a series of payments. Part of the payment will be tax free as a return of the death benefit, and part will be earnings on the money remaining with the insurance company, which are taxable.

There are two types of annuities that pay benefits over the life of one or more beneficiaries. A life income annuity pays the payment for the life of one beneficiary. When that beneficiary dies, the payments stop. A joint and last survivor income annuity pays the same or lesser payment over the life of two or more beneficiaries. The amount of the payment will be less than with a life income annuity, as the insurance company will probably have to make the payments for a longer amount of time.

Some annuities only pay for a certain period of time or a specific amount. A period certain annuity pays the payment for a specific number of years. This option can also be combined with the life income option. A specific income annuity pays the beneficiaries a specified amount until the death benefit and any earnings have been paid out.

While the beneficiary receives the death benefit without paying any income tax, the owner's estate may have to include the death benefit or the cash value as an asset when figuring estate taxes. If the owner and the insured are the same person, the death benefit will be included in the owner's estate for estate tax purposes even if the beneficiary is someone else. If the owner and the insured are different people, then the cash value is included in the owner's estate for estate tax purposes if the owner dies before the insured.

Celia Ray Hayhoe

See also Burial Insurance; Economic Evaluation of Life; Estate Planning; Estate Tax; Life Insurance Fraud; Viatical Settlements

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Life Insurance Fraud

Insurance fraud occurs when individuals deceive an insurance company or agent to collect money that they are not entitled to, or when insurers or agents engage in deceptive practices that have negative effects for consumers. Life insurance is a contract between an individual (policy owner), and the insurer, who agrees to pay a sum of money upon the insured individual's death or other event, such as terminal or critical illness. In return, the policy owner agrees to pay a specific amount at regular intervals, called a *premium*, or in lump sums. The person designated to receive the proceeds from the life insurance policy is called the *beneficiary*. Life insurance policies are often set up to cover the policyholder's bills and death expenses. In the United States, the most common form of life insurance specifies a lump sum to be paid upon the death of the policy owner. This entry describes life insurance fraud, discusses fraud by individuals as well as by agents and insurers, and ends with information on factors related to life insurance fraud.

Life insurance policies require the beneficiary of a policy to provide due proof of death when making a death benefit claim in support of which the beneficiary must submit a certified copy of the deceased's death certificate. A complete signed copy of the insurer's claim form is also required. Proceeds from life insurance policies may be paid as a lump sum or as an annuity, in which the funds are paid over time in regularly recurring payments for a specified period. If the insured's death is suspicious and the policy payout is large, an investigation of the manner of death will be conducted prior to the claim being paid. When a policyholder disappears without a trace and there is no direct evidence of the manner or fact of the insured's death, the claim may not be honored because so many such claims are fraudulent. In such cases, courts frequently allow the use of circumstantial evidence where the age of the insured would be beyond human expectation, where the insured's health was seriously impaired upon his or her disappearance, where the insured was exposed to danger or peril, and where the insured's absence is unexplained and evidence shows that the insured's character and habits are inconsistent with voluntary absence for the period involved.

Insurance fraud represents a major criminal activity in the United States. Fraudulent life insurance claims, estimated as high as $9.6 billion each year in the United States alone, are cause for the high cost of insurance that is absorbed by the consumer. One study conducted during the late 1990s examined 349 life insurance companies which, at the time, represented more than 93% of the U.S. life insurance market. The study authors reported that urban areas have higher rates of life insurance fraud and fraudulent claims and these claims are greatest in those regions of the country where people appear to accept such fraud as a way of life, where the unemployment rate is high, and where the economy is less than robust. The extent of existing laws does not appear to be a factor in the prevalence of fraudulent life insurance claims. Income and the existence of fraud penalties and punitive damage laws were not found to be related to the suspected fraud reported for each state. This same study reported that of 7,596 contested life insurance claims, only 43 had fraud listed as the reason for a denial of the claim. However, the majority of other reasons cited can be interpreted as fraudulent.

Life insurance policies include incontestability clauses, limiting the time an insurer has to contest the validity of an insurance policy based on material misrepresentations made by the policyholder during the application process (Alonso, 2006).

States began to require that life insurance policies include these clauses in the early 1900s. Claims related to fraudulent misrepresentation fall within these terms, so a claim that a policy is not enforceable due to fraudulent misrepresentation must be made within that limited period. The legislation behind such clauses serves to protect beneficiaries from insurers who may refuse to honor policies, minimizing costly litigation.

Life Insurance Fraud by Consumers

Consumers commit two types of insurance fraud, namely, hard fraud and soft fraud. Hard life insurance fraud involves an individual or group faking a death to collect on the life insurance policy. Soft life insurance fraud involves the documentation of inaccurate information submitted to the insurance company on applications or other documents.

Individuals sometimes purchase life insurance for themselves and then fake their death to collect on the insurance proceeds. Most of these individuals travel to another country and support their death claim with fraudulent documents, but very few are successful because insurance companies generally investigate all foreign death claims. For example, claimants dug up a recently buried body and staged an accident, after which one of the individuals claimed the "accident victim" to be the policyholder. After burial, the beneficiary filed a life insurance claim. When such fraud is uncovered, criminal charges filed lead to prison sentences.

In some cases, individuals purchase life insurance policies for other individuals and then attempt to collect on the insurance proceeds upon claiming that individual to have died. In some cases, the person reported to have died has no idea that another is filing such a claim, whereas in other cases there is collaboration between individuals to defraud the insurance company. There have also been instances in which individuals purchased life insurance policies on a spouse or child, or even an animal, murdered that individual, and attempted to collect on the life insurance policy proceeds. In the early 1900s in England, there was a rash of child homicides committed for gain through life insurance fraud following a ruling that coroners could not inquire into the death of a child. The ruling was quickly rescinded, thereby allowing coroners to investigate all sudden, unexpected deaths.

Life insurance fraud also occurs as a result of suspicious or questionable actions by the applicant or policyholder, such as misrepresenting health status or applying at a suspicious time in relation to the insured's death. One type of fraud occurs when individuals with a life-threatening illness apply for a new life insurance policy without disclosing the truth about their health. Cases have also been documented in which individuals open life insurance policies on family members but have healthy individuals submit to the medical examination in place of the actual family member who is in poor health.

Another type of life insurance fraud occurs when individuals who are healthy indicate that they are terminally ill in order to viaticate a life insurance policy, receiving a viatical settlement, or a percentage of the face value of the contract. A viatical settlement is the discounted, predeath sale of an existing life insurance policy when the insured is known to have a terminal condition. Viatical settlement fraud occurs when misrepresentations are made on insurance policy applications, concealing the fact that the applicant has already been diagnosed with a terminal condition. Fraud also occurs when misrepresentations are made to viatical settlement investors by the viatical companies regarding the life expectancies of the insured or guaranteed high rates of return.

Life Insurance Fraud by Agents or Insurers

The elderly are often victimized by unscrupulous insurance agents who sell policies that do not actually exist. The victim pays the premiums based on the belief that a policy exists, but no money is paid upon their death, as the policy was fraudulent. An insurance agent can sell fake coverage from a nonexistent insurance company, or can sell fake coverage under the name of a legitimate company. The individuals who believe they are purchasing a life insurance policy may receive an official-looking policy or proof of coverage that is worthless.

Yet another form of life insurance fraud occurs when agents pocket the applicant's premiums rather than forwarding the fee to the insurer. Again, the applicant believes an insurance policy has been issued, but the policy is in fact not current and is, therefore, invalid. Finally, life insurance fraud occurs when insurance company insiders

embezzle company funds, leaving no or very little money to be paid out to policyholders.

Sliding, Churning, and Twisting

Many individuals are victimized by insurance agents who sell overly expensive or unnecessary coverage or may even be covered in an existing policy. Known as "sliding," this activity occurs when an agent sells extra coverage that was not requested, but the individual pays for the extra coverage without knowledge that the payment is based on a separate, unsolicited policy. Examples of such policies are motor club memberships, accidental death coverage, and guaranteed renewable life insurance.

"Churning" occurs when deceitful agents, with the purpose of receiving a commission, convince individuals to use the built-up value of their current whole life insurance policy to buy a "superior" policy even though the existing life insurance coverage is sufficient. The victims spend their built-up cash value and must start building the cash value associated with the new plan all over again.

"Twisting," which is similar to churning, occurs when an agent urges an individual to change policies prematurely without being forthright about the negative aspects of changing policies. Individuals with a preexisting illness or other medical condition, for example, may not have coverage under a new policy.

Factors Related to Life Insurance Fraud

A catastrophe often leads to a large number of fraudulent claims; life insurance claims are filed for people who are stated to have died in the catastrophe but are actually still alive. Following the attacks on the World Trade Center on September 11, 2001, and the tragedy of Hurricane Katrina on August 29, 2005, many individuals filed fraudulent life insurance policies, claiming that family members died during such tragedies. Some individuals who filed such fraudulent claims were sentenced to federal prison terms after investigations had revealed the individual stated to have died was actually alive.

At the end of 2007, the Federal Bureau of Investigation (FBI) was investigating 529 cases of financial crime, with 209 of those cases being related to insurance fraud. The FBI expects the number of fraudulent claims to increase after several recent natural catastrophes. Soldiers also are at risk of fraudulent life insurance policies, as deceptive salesman attempt to sell policies that contain restrictive clauses that limit the payment should a soldier be killed or injured in the line of duty.

Most insurance companies have strict policies to prevent fraud, but some companies pay suspicious claims too easily. Indicators of life insurance fraud by applicants, policyholders, or third party claimants are as follows: The death of the insured occurred shortly after the policy's inception; the claimant had several small policies, often requiring no physical exam; evidence is found of financial distress directly prior to death; recent changes in coverage were made, generally in increments not requiring physical exams; recent changes in beneficiaries were made; the insured was involved in an activity not considered customary for the individual when he or she died; the body of the stated insured is never found, or identification is incomplete due to the condition of the deceased; and the coverage amount does not coincide with the insured's income or estimated net worth.

Patti J. Fisher

See also Coroner; Coroner's Jury; Life Insurance; Viatical Settlements

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Life Review

Life review refers to reminiscence in revisiting and evaluating one's life experiences, often at the end of life. Life review has been described as the relatively systematic reflection upon one's life and personal history. Like a story, life review encompasses an assessment of life's vicissitudes with all of its triumphs, successes, and failures, of life's twists and turns. The life review process is commonly used by professionals in conjunction with the dying elderly, but it is utilized in a range of settings. The concept has broad appeal because a specific therapeutic approach or discipline is not required.

For the dying, life review affords an opportunity to take the listener to where the dying person needs to go, to revisit the past. Often this means embarking on a series of painful experiences that did not turn out well. As reviewers have an opportunity to revisit and thereby reprocess part of life, they often develop new insights, allowing them to redefine if not accept a life event they must learn to integrate into whatever time they have remaining. It is through life review that individuals find that their life has meaning.

Developmentally life review facilitates the final psychosocial life stage, "integrity," as described by Erik Erikson, who proposed all individuals accept life as it is lived with no substitutions. In so doing, a person experiences integrity rather than despair.

A critical component of life review is the relationship established between the reviewer and the listener or any individual who commits to being interested in the reviewer and communicates that interest to increase interpersonal rapport. Life review occurs when trust is established in that relationship. It requires a secure environment and a caring relationship to facilitate the sharing of private thoughts and life events that are viewed in a negative context. Successful life review is based on acceptance without judgment. Although the listener may hear expressions that are difficult to accept or understand, and be exposed to issues that are contrary to their personal values, it is important the listener maintain a neutral posture lest the negative nature and feelings of the past event be reinforced in the speaker.

Intended to benefit the reviewer, the experience can also benefit family members. But life review is not intended to resolve family conflicts. It is also true that the reviewer may desire to share with someone outside the circle of family and friends. Described as the "stranger sitting on the airplane phenomenon," there is therapeutic value when the stranger leaves, taking all the secrets with him or her.

It is not uncommon for the review to be presented in a harsh manner. Thus, one skill important for the listener to develop is "reframing," allowing the reviewer to move to a new understanding of past events while evaluating the past in a balanced context.

A variation in life review is useful for enlarging the family's oral history. These methods include writing, audiotapes, and videotapes. Music, home videos, pictures, and treasured mementos also are useful for stimulating the telling of stories. They are natural connectors to a variety of times and places in their lives.

Life review is accomplished through formal and informal techniques in end-of-life care. Formal techniques include the "psychosocial history" to identify important life events, which can be transferred to a "psychosocial plan of care," a living document prominent in hospice care. An informal tool used for life review is known as "Reminiscence: Process and Outcomes." This is an effective tool that walks the listener through an overview of life review that is user friendly and demonstrates how life review can be broken down and simplified.

Some research findings suggest that life review is associated with reduced depression, improved memory, enhanced self-esteem, and improved ego integrity and social well-being. The potential benefits for developing life review skills will become more apparent as the baby boomers continue to age and are faced with the challenge of finding "integrity" rather than despair in their golden years.

Jack LoCicero

See also Aging, the Elderly, and Death; Caregiving; Death Anxiety; Life Cycle and Death

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Life Support Systems and Life-Extending Technologies

More than other technologies, life support systems and life-extending technologies symbolize the ethos of modern medicine to defy death or at least postpone it. Life support systems provide a partial or total substitution of major bodily organs and functions, while life extension technologies seek to increase one's maximum or average life span by improving and upgrading those functions.

Life Support Systems

Life support systems are therapeutic innovations—biochemical and technological—that substitute and support vital bodily functions such as respiratory and cardiac function, blood circulation, bodily temperature regulation, detoxification and filtering (i.e., replacement of kidney function), immunity function, nourishment and hydration, sometimes for long periods of time.

The Intensive Care Unit

The intensive care unit (ICU) is a highly specialized life-support environment coordinating the provision of constant monitoring and support of vital body functions. The purpose of ICU units is to "resuscitate" and maintain critically ill patients alive, not to cure the underlying disease. Even if organized efforts to resuscitate and ventilate people date from 1769 with the Society of Resuscitation of Drowned Persons, in England, the conception of the ICU as a life support environment was not realized until 1953 in Copenhagen. Regular life support technologies in the ICUs and emergency units are defibrillation for cardiopulmonary resuscitation (CPR), mechanical ventilation, heart/lung bypass, dialysis, intravenous drips, vasopressures (e.g., adrenaline) and antibiotics, bodily temperature control, and intubation for total parenteral and enteral hydration and nutrition.

CPR consists in the restoration of breathing and heart function. CPR as first aid is a simple "mouth-to-mouth respiration" technique to supply air to the lungs, and rhythmic chest compressions to maintain circulation and the oxygen supply to the brain and other vital organs until more advanced life support such as defibrillation can be provided. In defibrillation a low electrical shock is delivered to the heart with an automated external defibrillator until the normal sinus rhythm of the heart is restored. Advanced cardiopulmonary resuscitation in addition to defibrillation includes mechanical ventilation (assisted breathing), anti-arrhythmic drugs, vasopressures (drugs to stimulate circulation such as adrenaline) and postresuscitation care.

Mechanical ventilation—that is, the substitution of respiratory function by a ventilator, an external device pumping air and oxygen in and out of the lung—provides the most emblematic image of life support. A first breakthrough in assisted ventilation was the iron lung—an airtight coffin-like box that enclosed the body of the patient keeping the head outside and rhythmically pressured and

de-pressured the chest forcing air into the nose and lungs. The iron lung was devised to rescue victims of the polio epidemic of 1920s (poliomyelitis was a viral infection that destroyed nerve substance and led to temporary or permanent paralysis—including respiratory paralysis and ultimately death).

Another major turn took place during the next polio epidemic in 1952, when Danish anesthesiologist Bjorn Ibsen discovered the principle of the modern ventilator as a better alternative to the iron lung. The air was to be supplied via *intubation:* a tube (endotracheal tube) placed in the airway passage (mouth or nose) or directly into the trachea through a small surgical incision.

Pacemakers, Implantable Cardioverter-Defibrillators, Left Ventricular Assist Devices, Artificial Hearts

Pacemakers and implantable cardioverter defibrillators (implantable medical devices developed to correct cardiac rhythm disturbances) and ventricular assist devices are mechanical blood pumps that replace part or the entirety of the heart's function and are utilized to bridge heart function during heart transplants. The total artificial heart is an implantable mechanical device still under development but being used to alleviate and increase the short-term survival of patients with end-stage heart failure (e.g., patients waiting for a heart transplant).

Dialysis

Dialysis is the process of removing salts and impurities from the blood, a process normally performed by the kidneys. If the kidney fails to perform this function, the result will be death within a few days. Dialysis is carried out as *peritoneal dialysis* (via the intestine) or as *hemodialysis* (via a shunt or in the arm), and during several hours blood is taken, filtered, and returned to the patient's body. Dialysis is the only alternative to kidney transplantation in managing acute renal failure (e.g., resulting from poisoning) or chronic renal failure (e.g., resulting from hypertension or diabetes).

Life-Sustaining Antibiotic Therapy

Antibiotics are first-line tools in the control of life-threatening systemic bacterial infections in emergency services, such as acute bacterial meningitis, pneumonia, septic shock, tuberculosis, or secondary infections in HIV/AIDS. Recent studies suggest that known antibiotics may not be highly effective in the future due to the spread of super-resistant bacteria.

Enteral and total parenteral nutritional support and hydration are used for patients unable (or unwilling) to swallow or digest food or fluids taken by mouth; these patients risk dehydration, malnutrition, and eventually death. The two methods of providing artificial nourishment and fluids are enteral nutrition, in which a nutritional "formula" is delivered trough a feeding tube into the nose, mouth, or surgical opening into the digestive tract, and total parenteral nutrition, in which nutrients are supplied intravenously via a catheter directly into the bloodstream.

Ethical, Social, and Legal Issues in Life Support

The availability and utilization of life support seems to sustain the notion that if we have the technological means to "save lives," we are duty-bound to utilize them. Life support has truly saved lives to an extraordinary extent, yet these technologies bring about the unexpected side effects of prolonged lives (in many cases, with serious impairments and disabilities), and prolonged death processes. Such side effects have garnered mass media attention and public debates about the right of patients to refuse life support, the sanctity of life, and the medical obligation to save lives. Cases such as Nancy Cruzan, Karen Quinlan, and Terri Schiavo in the United States are indicative of these controversies. Other issues raised by the success of life support interventions are elevated costs to health care systems. In the United States in particular, where thousands of people are uninsured, the cost of life support technologies are debated.

Life-Extending Technologies

While life support focuses on salvaging life and sustaining vital functions in crisis situations, life-extending technologies aim to minimize and even cancel the detrimental impact of the environment on human cells and tissues, reducing the rate of aging at the cellular level. Some of the same technologies used for life support are also used for life

extension: dialysis, organ transplantation, insertion of pacemakers, implantable cardioverter-defibrillators, left ventricular assist devices, continuous chemical and antibiotic therapy, and nutritional support. In addition there are a variety of "therapies" and practices relating to healthier lifestyles, including exercise, diet and nutrition, as well as the use of a wide range of medicines and medical therapies. These therapies include:

Caloric Restriction

Several animal studies indicate that a 40% caloric restriction extends the life span almost by 50%, lowering free radicals and oxidation damage. However, even a milder caloric restriction of 20% will activate *sirtuin,* a protein responsible for neutralizing aging. Sirtuin is also activated by *resveratrol* (found in grape seeds and red wine) and by exercise.

Bodily Exercise

For some decades there has been growing awareness of the value of regular physical activity for good health and longevity. A variety of guidelines, programs, and styles have been developed. Particularly noteworthy is the engagements of older persons in exercise, both aerobic and brain exercise. There is evidence of substantial preventive value in exercise against the primary and secondary prevention of cardiovascular disease, cancer, diabetes, rheumatism, and neurological disease, for example.

Supplements and Antioxidants

Supplements and antioxidants such as vitamins, minerals, enzymes and other substances can be understood as marketed technologies directed at preventing aging.

As we age, our brains age too, conveying an increased risk of neurological diseases such as Alzheimer's disease. Aspirin, B and E vitamins, the extract of the plant ginkgo biloba, green tea, and coffee seem to prevent "brain aging" by reducing inflammation and oxidative stress in brain tissue. Vitamin-like substances like omega-3, phosphatidylserine, carnitine, lycopene, cinnamon, turmeric, red pepper, lutein in green vegetables, and quercetin in onions and garlic are also recommended for a life extension diet.

Antioxidants also play an important role. Most of the oxygen we inhale is transformed into energy by the mitochondria (mitochondria are body cells responsible for the generation of energy and essential components of metabolism), but some it turns into oxidants damaging the cells. Common antioxidants are vitamins A, C, and E; selenium; and melatonin (a hormone produced by the pituitary gland). Enzymes such as glutathione, coenzyme Q10, alpha-lipoic acid, and superoxide dismutase also protect the cells from damage from free radicals.

Hormone Replacement Therapy

Several hormones decline with age. For example, low levels of DHEA (dehydroepiandrosterone sulfate; a hormone produced by the adrenal glands), human growth hormone, and testosterone correlate with degenerative diseases and autoimmune disorders. Whereas some studies have shown that steroid replacements improve several functions in elderly patients, others have yielded contradictory findings and complex side effects.

Biotechnological Approaches to Life Extension

Biotechnological interventions focus on the replacement of damaged organs and, alternatively, on replacements at cellular and DNA level.

One proposed solution to aging is the replacement of damaged organs with natural clones, or artificial organs manufactured in some durable material. Yet, organ replacement cannot be an optimal solution to aging, as the key to restore aging is to operate at molecular level, replacing and repairing damaged cells with therapeutic cloning, nanotechnology, or by modifying the genetic program to prevent the aging process. *Therapeutic cloning* uses stem cells to replace damaged cells. Stem cells are undifferentiated cells that have the potential to become any type of cell in the body and that produce telomerase, an enzyme that rejuvenates the cell extending the number of times it can divide, almost indefinitely. These cells can be grown, genetically modified, and then implanted in the body to replenish older cells. *Gene therapy* consists in the manipulation of genes associated with aging. Gene therapy research has managed to significantly extend the life span in worms and mice. *Nanotechnology* aims at building minuscule robots to go into the cell and

reverse age-related damages, a promising but still theoretical strategy.

Ethical, Social, and Legal Issues of Life Extension

Human life expectancy has increased twofold in the past century, due to better social, biomedical, sanitary, and dietary conditions, and as a result of decline in infant mortality. The maximum human life span, however, has not increased at the same rate. Few individuals live to be 100 years (although there many individuals older than 100 years in Japan, and this population is expanding at more than 5% per year).

Aging is no longer defined as a natural decay, but rather as a failure in the mechanisms of maintenance and repair at a biochemical level. After a certain number of replications, the process of cell division declines and finally ceases. The accumulation of molecular damage in the cells triggers diseases associated with aging, such as atherosclerosis, cardiovascular diseases, dementia, and cancers, among others.

While interventions in lifestyle and nutrition generally aim at increasing life expectancy, radical life extension proposes to develop biotechnological interventions to revert cellular damage, increasing the maximum life span to 130 years or more. Proponents of this perspective even foresee an indefinite postponement of aging.

The radical life-extension program has raised much debate around the possible consequences of living really long lives. Opponents to these attempts argue that radical life extension is unnatural and to a sense immoral; that extreme long lives would lead to overpopulation and that life extension would probably become a prerogative of wealthy elites. Proponents argue that diseases too are natural, and that this does not make them good. Moreover, preventing the onset of age-related diseases by intervening in the basic process of aging is the best way to improve the quality of human life. Many of these debates are highly speculative and theoretical. But, for the first time, research in radical life extension, by intervening in the senescence process, makes the possibility of postponing death a realistic and extraordinary prospect.

Nora Machado

See also Death in the Future; Discretionary Death; End-of-Life Decision Making; Organ and Tissue Donation and Transplantation; Quality of Life; Resuscitation

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Literary Depictions of Death

Although death is a prominent theme in literature from the most ancient times to the present, it has always been depicted in connection with other themes. Scholars of the past century noticed that death was the source of most myths. In fact, symbolic or imaginative representations of death are found in some form in every culture, first as a revelation, then as a sacred tradition and finally as an exemplary model. Thus, the theme of death goes hand in hand with the evolution of literature, both in oral and written practices, and including all genres and species.

In the history of collective attitudes about death, it was thought that death representations were

mirrored by the extant societies and the successive epochs. Yet, figures of death may be totally contextualized; they spring from our own imagination. Consequently, death is difficult to define as an object; we can only conceive it as metaphor, allegory, dislocation, allusion, or play on words. This entry briefly reviews the historical background of the literary depictions of death. It then focuses on how literature helps us understand death as a human experience and as a pretext for writing. Finally, it examines modern approaches to death in the field of literary criticism.

How Common Understanding of Death Affected Literature

Ancient literature focused on the cult of the dead through epic poems, songs, and tragic plays. Medieval life, and thus its literature, was driven by war with death depicted either as a vision of horror or of heroism, depending on authors' goal to condemn or to praise war as a means to write history. In Dante Alighieri's *Divine Comedy,* the Arabian motif of the trip into the other world becomes central. It is filtered through Christian ideals as an allegory of the different states of mind that a person can experience. Thus, Inferno stands for evil and vice; Paradise is the image of good and virtue, and Purgatory is the transition between the two by means of repentance and expiation.

The Renaissance period, with William Shakespeare as the most representative figure, revived tragic stories of Greek antiquity and refurbished them in a way that put together love and death, bringing the tragic to paroxysm. French classicism continued the tradition of what scholars called "the theater of great passions," although with a sense of property and civil responsibility. The legendary characters such as Medea, Phaedra, and Iphigenia were no longer marionettes in the gods' hands, but victims of their own passions.

Seventeenth-century English Puritanism considered death by imagining the life beyond. John Milton's *Paradise Lost* is a transcription of the biblical myth as an allegory of the puritans' struggle against absolutism and aristocracy. However, after the publication of the *Encyclopédie* in France in the 18th century, the preoccupation with life after death was condemned as a form of putting down life on earth.

At the same time in England, the black novel was born, with its terrifying, gothic depictions of haunted castles, which have since inspired modern thrillers. Obsession with death was already a preromantic theme with the so-called poets of the dark, to whom the effusion of the mourning and the attraction of the tomb were constant sources of meditation. Cemetery wandering, vampirism, melancholia, and predilection with suicide were preferred literary themes during the 19th-century periods of Romanticism, Parnassianism, and Symbolism, which were followed by existential questioning upon "le mal du siècle" during the 20th century. The shocking experiences of the past century marked literature with grave accents of pessimism and nihilism. Themes of collective death (plague, genocide) and suicide promoted the idea of the absurdity of life and the belief that human destiny was mere chance.

Later Influences on Literature

Literary themes tend to follow the realities of the epoch. For Victorian writers during the Industrial Revolution, the theme of child death was very prominent, involving Christian strategies of consolation. Medical progress also impacted literature—in naturalist theory, the onset of death was no longer a punishment, but a consequence of the progressive disintegration of the organism.

Eventually, the theme of the apocalypse, or end of the world, gained in popularity. Thus, science fiction explored the territories of the imaginary through the depiction of cosmic dangers, biological disasters, or man-made disasters such as widespread nuclear war. Whether these literary trends inherit from the biblical myth of the apocalypse or announce the ecological movement, anxiety grew with the representation of nothingness. Scholars said that the theme of the end of the world is as old as the fear of dying. However, literature has always managed to surprise contemporaries as did J. B. Cousin de Grainville's tale of the last man on earth. He imagined the possibility of the human species becoming sterile around the same time Malthusian theory emerged. In de Grainville's novel, to prevent mankind repeating the same wars and horrors, Omégare chooses not to go and meet the last woman on earth.

Death as a Human Experience

Both poets and writers have been inspired to write about death. Writing about the death of others implies a testimonial function of literature while the reference to the self is merely fantasy and imagination. However, scholars figured out that writing of the death of others means mastering the fears and anxiety related to the death of self.

The Other's Death

The literature that developed around the other's death attempted to explain the causes of death through crime, war, natural disasters, and, very late in the 19th century, organic decomposition. The accent was on the survivors and their mourning, bereavement, and grief, either in a psychological dimension or in a ritual one. Literature praising the dead emerges from the ritual, but it has also the mental function of the duty that the living have to the dead. What comes after death is not found in science, allowing fiction free rein. Literature about life after death embraces motifs such as the trip into the other world (*Gilgamesh,* Dante, Milton), the dead speaking (François Villon), ghosts and vampirism (Bram Stoker), resurrection (the Bible), nirvana (Mircea Eliade), and the quest for immortality (Celtic legends of the Saint Grail). They all express human attitudes toward the mystery of death: fascination, fear, pity, sorrow, and denial. Concepts of death ranged from the means of access to another world or state (from substance to essence), to the irremediable end. For instance, in the symbolist theater (Maurice Maeterlinck), nothing happens but the tense waiting for the fatal force of death: The characters are paralyzed with fear and ramble in vague foreboding and mysterious impulsiveness.

The Death of the Self

The death of the self is not always feared but sometimes is desired. Indian literature portrays self-sacrifice as a conscious effort to transgress the human limitations in order to proceed to holiness or nirvana (*Upanishad*). Indeed, many social attitudes pertaining to suicide were influenced by the writings of the great thinkers and philosophers. Suicide was officially condemned by Cicero, Plato, and Aristotle, though in reality such self-destructive behavior was tolerated. Seneca's letters on death and suicide would remain for centuries a reference for the defenders of absolute liberty.

However, it is with the *Sturm und Drang* and the romantic dolorism movements that life began to imitate literature. Overwhelmed by an unsatisfying present, authors turned to the past, contemplating the graves and ruins; they were attracted by death as it delivered the spirit from the bodily prison, from an existence of suffering and a world of injustice. Thus, the cemetery became a favorite landscape. Disgusted with life, figures like young Werther in Germany (Johann Wolfgang Goethe) and René in France (René de Chateaubriand) became obsessed with the feeling of death, an obsession that was emblematic of the times and, concomitantly, held great influence upon the literature of the period.

In contrast, suicides such as that of Emma Bovary in Gustave Flaubert's naturalist novel, of Kiriloff in Fodor Mikahaïlovitch Dostoyevsky's realist novel, or of Jessie Cates in Marsha Norman's modern drama represent a different constitution. These suicides are sobering in presentation and professional literary critics of the time underlined their simplicity and veracity in opposition to the romantic suicide with its artificial hatred projected toward the world.

The Parnassians displayed an inner, grave, meditative attitude in their poetry, with a central place for the figure of death. Characterized by pessimism and Buddhist nihilism, the Parnassians considered pain inseparable from existence; aspiring to the nothingness of death seemed the only remedy. Charles Baudelaire excelled in depicting the history of a thrilling spiritual drama, a lifelong moral crisis that only found consolation in the temptation of a delivering death.

After World Wars I and II, suicide was increasingly apparent in both literature and reality. The absurdity of life depicted by existentialists has been interpreted as an attitude of avoidance, of dismissal in the face of the harshness of life. Some writers, however, such as Emil Cioran used expiatory literature as an alternative to the self-destruction impulse.

Eros and Thanatos

When analyzing literary depictions of death, scholars render special consideration to the theme of love, or the aspect of the oedipal complex. In *L'Amour et l'Occident,* Denis de Rougemont

developed the idea that since *Tristan and Isolde,* it has been impossible for writers to conceive of the theme of love without its concomitant relationship to death being considered. For instance, throughout the works of Marguerite Duras, there is a constant theme that partners *Eros* and *Thanatos;* the feminine character is only strengthened by the passion that violently pushes her lovers to suicide.

Historically, suicide has often been a form of blackmail as a strategy to regain love, for many thought that life without love is similar to death. The tragedies of the era depict the suicide of young people, victims of cunning schemes to disrupt their loving relationship. Again, in the sentimental and the romantic novel, death is the consequence of a broken heart as witnessed in *Clarissa* by Samuel Richardson, *Julie, or The New Heloise* by Jean-Jacques Rousseau, *The Young Werther's Sufferings* by Goethe, *Poor Lisa* by Nikolay Karamzin, and *Last Letters of Jacopo Ortis* by Ugo Foscolo.

Death as a Pretext for Writing

In general, grief and mourning are represented to assist in identifying fiction from history. However, this technique is not useful when applied to early literary works, because knowledge of those times is based solely on these same writings. Such tautology is not consistent with the emerging scientific ethos.

The Origins of Literature

The most ancient written literature are texts connected to the cult of dead (*The Book of the Dead, The Texts of the Sarcophagus, The Texts of the Pyramids,* Egypt, ca. 3300 B.C.E.). Based on popular verses, some incantation-like songs of sorrow evoke moments from the life of the departed while others try to prevent an enemy's spirit from returning to disturb the community (South America). The Sumero-Babylonian *Gilgamesh,* 28th century B.C.E., the earliest known literary work, contains the embryonic seed of mourning, death anxiety, and the quest for eternal life, or the secrets of the life beyond. A few centuries later, other writings were imbued with skepticism and profound pessimism in reaction to the official system of belief in life after death (*Conversation of a disappointed with his soul,* Egypt, 22nd century B.C.E.) or expressed the vanity of life (the Egyptian *Song of the Harpist,* the Hebraic *Ecclesiastes*). Indian and Greek funerals and religious hymns circulated in oral form until they were included in anthologies (*Rig Veda,* 1200–500 B.C.E.) or epics (*The Iliad,* 9th century B.C.E.). Thus, the motif of death such as mourning, bereavement and grief, life after death, and funerals are already present in literature. These themes developed throughout the centuries, in turn giving birth to other themes such as vampirism as a modern imagining of the life beyond.

Families Decline

Depictions of death have served well to explain the decline of the structure of the family. From the Indian epic (*Mahabharatta*) and Greek "theater of great passions" to German medieval literature (*Nibelungenlied*), Shakespearean tragedy (*Romeo and Juliet*) and French naturalist novels (*Thérèse Raquin* by Emile Zola), authors relied upon criminal impulses to cause the death of family members.

As a prototype of this genre, Eschol, Sophocles, and Euripides depicted intrafamily murders, with the underlying meanings ranging from the work of gods to human responsibility. In these works, the characters undergo the most violent, passionate, and tragic situations: A daughter is sent to death by her own father; a wife willingly sacrifices herself to save her husband; a mother kills the children of her son's murderer; a seduced and abandoned woman kisses her children good-bye before putting them to death; or a sister breaks the law in order to accomplish a funeral ritual.

With Shakespeare (*Hamlet, Macbeth, Othello*), the accent is placed at the level of the moral consciousness so that the murderer was no more than a victim. While French classicism, and later existentialism, also returned to the antique virtues of purity, the same mythic material of the past emerged with a sense of property and civil responsibility (Pierre Corneille, Jean Racine, Jean Anouilh, Jean-Paul Sartre).

Death Literature as an Entertaining Personality Cult

Personality cults developed and spread with the expansion of civilization during the Renaissance period, transforming the figurative representation of great persons as well as the manner in which

their lives were narrated. New literary forms and genres reconsidered the relationship between life and death. For these writers, literature was, and it remains, a way of being remembered (a postself) after death. Thus, the written text serves as a monument as well as a funeral tomb. Three centuries later, the French writer Alexandre Dumas commemorated his friend Nodier by writing a novel that, despite its expressed intent, turned out to be a pretext for Dumas to write his own eulogy.

Fascination of Death

Presenting the other as a viewpoint of the dead can help writers (or readers) assuage their fears and help master their fantasies about death. Through *belles lettres,* or savant discourse, literature examines the fascination of death through the representation of gladiators, martyrs, executions, or assisted suicides. However, recent literature takes a different track, no longer seeing this mysterious attraction as curiosity, but rather as thrill and charm. In the past century, as writers found that people had difficulty accepting tragic representations, death came to be portrayed as a humorous character (Terry Pratchett) or a cartoon illustration (Neil Gaiman).

Accordingly, in 1988, a group of multicultural collectors, in an attempt to lessen the dramatic representation of death in the Western world, gathered stories of celebration of the dead, including funerals and rituals, and especially plays, carnivals, and other happy festivals. The work was published in France; it led to the conclusion that the idea of death could be sublimed, transformed and transferred through sensations provided by language. Indeed, poetry and other forms of literature are ways of immortalizing the dead and death itself.

During this same period, Ruth Menahem argued that the need to write is inseparable from the wish to die. Language is a medium for impulsive representations to express oneself, so that the unconscious desire may accede to the conscious mind. Thus, the goal is to study the way in which fantasies of death are put into writing.

The Latter 20th Century: Critical Studies and Literary Depictions of Death

Literature reflects contemporary societies' understanding of death, whether the framework is religious, humanist, part of nature, or the disruption of life. Historically, the theme of death was within the purview of the metaphysicians and necromantics. During the latter portion of the 20th century, however, much interest was generated within a number of academic disciplines and practitioner-oriented professions, including history, psychology, anthropology, sociology, and medicine. It is within this context that literary critics provide increasing attention to literary depictions of death. Examples can be drawn for the work of Paul Barber who, in 1988, distinguished between the vampire of folklore and the vampire of fiction. He eventually investigated burial practices and finally considered death between folklore and reality. During the 1990s, Daniel E. Collins wrote of the treatment of death in Russian medieval literature. He identified six recurrent motifs in the description of the Muscovite monks' last hours (presentiment of death, last rites, transfer of power, convocation and admonition, obedience and the testament, parting forgiveness and blessings).

Collecting stories from the oral traditions around the world was also a major preoccupation of the 1990s, meaning to balance the silence that resulted from the institutionalization of the dying in modern societies. If some literary collectors put the accent on the festivities attached to the event of death, it is mainly to replace death among the living, as it was in ancient times.

Finally, the religious influence upon the literary works of the West was recognized by Allan T. Smith in 2006. Laurence Lerner focused on the Christian strategies of consolation with reference to child deaths depicted during the 19th century, while some feminist scholars gathered poems skillfully written by bereaved parents during the 17th and the 18th centuries.

Cristina Dumitru-Lahaye

See also Death, Humanistic Perspectives; Depictions of Death in Sculpture and Architecture; Depictions of Death in Television and the Movies; Language of Death; Mythology; Postself

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Living a Legacy

The lives we lead are in themselves a legacy—mostly for good but sometimes not—although we may give little thought to what that legacy might contain. The immensely wealthy are able to leave a living legacy in the form of charitable foundations named after individuals or families who are thought to be inspirational, such as Ford, Fulbright, or Rockefeller. Such structured benevolence serves as a guiding light, be it through a devotion to art, education, medicine, or environmental protection.

A living legacy for most of us will be memories for family and friends and, for a few, an impression made on a larger stage. Some find it hard to contemplate their own demise but for those who can, thinking about the legacy they wish to leave enables them to generate a list of what they want to achieve and prioritize competing claims on their time and energy. Some goals are externally directed—for example, popular lists of 100 places to visit (or eat) before you die (a form of tourist and restaurant promotion)—in pursuit of new experiences. Others are more inclined toward a reflective lifestyle, mindfully appreciating and living the moment.

A positive awareness of the inevitability of death can intensify our appreciation of life. It encourages us to be more open with family members and to challenge the taboos that surround the subject, thus increasing the likelihood of achieving a "good" death, one without regrets. However, for many the reality is a sense of anxiety and denial about their own demise. Death anxiety stems from three possible sources: past-related regrets, future-related regrets, and the meaningfulness of death. Regrets are mostly caused by unfinished business usually concerning (a) relationships and reconciliation with loved ones, mostly apologies and forgiveness issues in intimate relationships, and not having the opportunity or ability to express love; (b) completion of key life tasks such as witnessing the marriages of children or attending the graduation ceremonies of grandchildren; (c) personal challenges or commitments like running a marathon, writing a book, making a dress, or helping to build a school for AIDS orphans; and (d) failing to fulfill personal promises to family and friends, for example, giving up smoking, repaying a debt, or writing a letter of introduction.

Creating a Shared Legacy

Although these issues affect all of us, they may be felt more intensely by those from collectivist cultures—for example, Chinese, Latino, and Jewish—where family relationships and individual identity are closely interwoven and where individual achievements are frequently perceived as family achievements. A satisfying and meaningful life with gratifying relationships, opportunity to finish unfinished business, and adequate closure leads to a peaceful departure from this world.

The ways that individuals share their lives and create legacies for others vary. Writing an autobiography is a popular form of sharing one's life. Family members may also produce their own written recollections of the departed, usually focusing on their strengths, talents, and virtues. Poems, artwork, portraits, and songs may also be used to promote the collective memory of individuals or communities. Those left behind often turn to religion and spiritual comfort in a search for the meaning of loss. In a survey of emotional responses to the September 11, 2001, terrorist attacks in the United States, 90% of respondents reported turning to religion as a direct consequence. It is the unexpected death that often causes the most distress, especially when it involves people who have much of their lives left to lead. But this can also create opportunities for a tangible and life-saving legacy—organ donation. In some ways this is the ultimate act of altruism, as many such donations are made to unrelated people. Not everyone is

comfortable with this kind of legacy but for those who are it creates the feeling that death was not entirely in vain and consoles the bereaved with the sense that their loved one still has a living presence on this earth.

Living legacies can be ambiguous or even negative. Service men and women who die in battle are heroes within their own countries because they gave everything for a righteous cause. The same people are war criminals to the invaded nation(s). Japanese soldiers who survived defeat were expected to kill themselves. It was the only honorable action left to them. Unsurprisingly they despised as cowards allied troops who allowed themselves to be captured. Many of those allied troops had been brought up to believe that suicide was a coward's escape. One faith's religious fanatics are another faith's holy martyrs who die with honor and fame in this life and gain Elysium in the next. In China suicide was traditionally the last resort of those desperate to make their voices heard. Government officials whose policy recommendations were rejected by the emperor would not infrequently kill themselves as a means to demonstrate their dedication to the well-being of the empire as well as the justness of their policies; a piece of advice is more important than one's own life. Following this example, suicide is still used by Chinese people to make their voice heard, to highlight unfair treatment or undeserved blame. In some eastern cultures, remarriage by widows was (and to some extend still is) unacceptable. In China, widows who died without remarrying were commemorated through a memorial plaque in the ancestor hall, a singular honor. In India the position was more extreme; widows were expected to burn alive on the funeral pyres of their husbands, a practice known as *suttee* and now illegal but still practiced in some rural areas of India. Such living legacies represent oppressive traditions for women and that rob them of choice and freedom.

Clinical Aspects of the Concept

The concept of living legacies has a clinical application in preparing people for the end of their life in a way that can be colorful and diverse. Discussion of one's life legacy can generate a sense of coherence, integrity, purpose, and meaning; enhance connectedness; affirm self; and address the aftermath of trauma. Individuals can be helped through a discussion that shares life wisdom, by visiting favorite places and retelling stories about the past that can be passed to the next generation.

Removing risk factors and strengthening protective factors by awakening the reasons for living has become a key focus in prevention intervention. People do not kill themselves when there are reasons to live. A life review can introduce the concept of living a life that is fulfilled, during which missions are accomplished and many fond memories are created.

Life review as an anticipatory mourning intervention is useful for tapping into a person's "unfinished business" and facilitating a "good" death. Life review can bring the best of the past into a functional relation with the present so as to strengthen positive support. When past good memories are reviewed, one can share lessons of living, inspire and encourage others, and affirm the values and meanings of relationships. Structured life reviews also are effective in helping depressed older adults in the reduction of depressive symptoms and enhancement of their satisfaction with life.

Constructive reappraisal of past events can lead to improvements in self-esteem, personal meaning, a sense of purpose, and a decline in hopelessness. Integrative expression of past events not only can enhance memory and cognitive functioning, it can also facilitate recall of past coping strategies and enhance coping by normalizing the distress and adversities in life.

Discussions about the legacies of our lives help us to deal with death, dying, loss, and bereavement as well as their impact on the ultimate reasons for living. Not only do they provide chances for us to process the meaning of death and integrate it into reality, they also help us to imbue our lives with appreciation and meaning. Without death, there is no life; without love, there is no grief. Grief over the loss and death of loved ones demonstrates the existence of intense love. Joan Berzoff has cited many examples of living a legacy in her book and articles. In particular she has focused on how bereavement experiences can be transformed into new meanings and sense of self for individuals. The tendency to medicalize or pathologize grief may not be in the best interest of bereaved persons' recovery and transformation through pain.

The Role of Cultural and Religious Beliefs and Practices

Benevolent practices based on patience, humility, wisdom, knowledge, courtesy, courage, love, justice, temperance, and transcendence are values in action. According to Buddhist teaching, values such as compassion, altruistic behavior, unselfish love, forgiveness, and loving kindness are keys to happiness. The bondage of hatred, anger, and jealousy, as well as thoughts of retaliation and revenge can become mental toxins that poison individuals' physical and mental well-being. Conversely, compassion is the best medicine for anger and rage through altruistic actions to eliminate the suffering of other people. By involvement in acts of compassion and loving kindness, individuals' hearts can be cleansed and their souls can be freed. That is why relationship reconciliation is a crucial pathway to dying in peace.

Highly respected religious and political leaders are shared role models in the provision of a living legacy. The father of independent India, Mohandas Gandhi, is dearly remembered by the world for his leadership of the nonviolent resistance movement against colonial rule and international domination. He used the hunger strike as a form of passive resistance, almost killing himself in the process. Such devotion to peaceful political action through self-sacrifice has given Gandhi a unique page in human history. Mother Teresa is still one of the most respected spiritual leaders. She promoted simplicity, love, and unconditional compassion, especially to the dying and those considered by others to be human rubbish on the streets of Calcutta. Successful business leaders such as Bill Gates and retired politicians such as former U.S. Vice President Al Gore have shifted the mission of their lives. Gates has refocused his energies on giving away the fortune he amassed, and Gore now devotes his public life to raising international consciousness about the imminent and long-term dangers of global warming. These are new missions and directions that these inspirational leaders now believe to be the most important parts of their lives and intend to devote their futures to achieving. They are certainly living legacies for the rest of the world. They encourage us to know what we want to achieve and contribute to humankind in a lifetime, albeit in more humble ways.

The human legacy could be one of gracious and full living, leaving a legacy of love for others. Reflection back on life with its attendant challenges and difficulties should bring satisfaction along with personal endurance and humility. Remembering how we overcame adversity should help us to recognize our strengths and persistence. More importantly, revisiting our past should enable us to identify priorities in life. The accumulation of much life wisdom that can be shared with the younger generations as a living legacy can enhance a sense of altruism, benevolence, and transcendence. Preparing for such a legacy can foster an appreciation of life, as well as courage to face adversities with perseverance.

Cecilia Lai Wan Chan

See also Altruistic Suicide; Bereavement, Grief, and Mourning; Death Anxiety; Life Review; Postself

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Living Wills and Advance Directives

The medical profession in the United States has experienced a shift in ethics and values over the past 3 decades, from a position of paternalism to an emphasis on patient autonomy. As such, individuals are becoming increasingly involved in their medical care, especially with regard to decision making near the end of life. The desire to "control" the circumstances surrounding one's death has become the norm in the majority culture of the

United States, and several practices have evolved to help ensure that this is accomplished. Advance directives and advance care planning are two such concepts that are discussed in this entry.

Terminology

Near the end of life, patients and their families face a number of difficult decisions, such as whether to start or continue a given medical treatment. Advance directives are written documents that state an individual's wishes under specific conditions and in the event that he or she is no longer legally competent to make a decision. There are two general types of advance directives: durable power of attorney and living wills. A durable power of attorney (also known as a "health care proxy") designates an individual who will make decisions for the dying person when he or she is no longer competent to do so. A living will is a document that specifies in writing what kinds of treatment are and/or are not wanted by the individual under specific conditions.

In addition, there are two types of directives that are specific to certain treatment interventions: the do not resuscitate (DNR) order and the do not hospitalize (DNH) order. The DNR indicates that no resuscitation measures (typically cardiopulmonary resuscitation [CPR]) should be undertaken if the patient goes into cardiac or respiratory arrest. The DNH order states that the person or the responsible party (relative or legal guardian) does not want the person to be hospitalized. DNH orders are typically issued when an individual's pain management, comfort care, and current treatment needs can be met either at the person's home or in a nursing home. This does not mean that the patient can never be hospitalized, but simply that before the decision to hospitalize is made, a discussion needs to occur between the competent patient or patient's family/guardian (if the patient is incompetent) and the attending physician to determine if hospitalization is what is best for the patient.

History of Advance Directives

Although competent adults in the United States have long held the right to refuse life-sustaining medical treatment, individuals who were incompetent at the time a treatment decision was required, and their loved ones, had no option but to follow the decisions of the medical team. Marilyn Webb discussed several significant events that occurred between the late 1960s and the early 1990s and brought the concept of advanced directives to the attention of the public. This concept was introduced in 1967 when Luis Kutner, an attorney and member of the Euthanasia Society of America, proposed the first model of a living will. That same year, the Euthanasia Society began to distribute these model documents out to the public. In 1968 and again in 1973, Dr. Walter F. Sackett introduced a bill allowing patients to express their future desires regarding life-sustaining medical treatment to the Florida state legislature. However, the bill was defeated both times. In 1974, Barry Keene proposed a bill aimed at legalizing living wills called the Natural Death Act, but this too was defeated. It was not until the famous New Jersey Supreme Court ruling in the case of Karen Ann Quinlan in 1976 that proposals for advance directives were able to gain ground.

The events leading up to this case occurred in 1975, when the 21-year-old Quinlan went into a persistent vegetative state (PVS) after having accidentally ingested a potentially lethal combination of prescription medication and alcohol. At the time of her discovery, Karen had been unconscious and deprived of oxygen for at least 15 minutes, yet the medical staff used aggressive CPR in an attempt to revive her. All possible life-saving measures were taken to bring Karen out of the PVS, to no avail. After several months with no change, her medical doctors agreed that the chances were less than 1% that Karen would ever come out of the PVS. Her body had begun to shrivel and curl up into itself, and she would have frequent periods of involuntarily reflexes, such as grimacing, screaming, and crying. The doctors insisted Karen could not feel any pain, but it was very difficult for her family to watch her experience such suffering. After several months, Karen's family requested that her mechanical ventilator be removed so that she could die in peace. Karen's doctor initially agreed with Quinlan's family, but later recanted, stating it violated his moral values and contradicted established medical practice. This refusal began a long court battle for the Quinlan family who fought for the right to act as their daughter's legal guardian (because she was an adult at the time of her accident), and the right

to withdraw the life-sustaining treatment she was receiving. On March 31, 1976, 2 weeks shy of a year since Karen had gone into a PVS, the New Jersey Supreme Court ruled that Joe Quinlan, Karen's father, would be her legal guardian and would be entitled to make medical treatment decisions on her behalf.

According to Webb, 3 months after the Quinlan ruling, Barry Keene proposed his bill once again, which, this time, was successful. With the passing of the Natural Death Act, California became the first state to legalize one type of advance directive, the living will. By 1977, 42 states had made similar proposals, with seven of them passing. In 1983, California made yet another significant step forward and enacted the Durable Power of Attorney for Health Care law, becoming the first state to recognize this type of advance directive. Finally, by 1992, all 50 states had legalized some type of advance directive. Despite the legalization of living wills and durable power of attorney, incidence rates of completed advanced directives remain very low.

In 1983, another famous case brought public attention to how laws regarding an individual's right to die can vary by state. Nancy Cruzan was a 25-year-old woman who went into PVS after a serious car accident. She had been fed through a feeding tube inserted into her stomach for 4 years before her family asked the rehabilitation center to remove her feeding tube. When the center refused, fearing they would be committing murder, the Cruzans took their daughter's case to court. The Missouri courts, however, were initially reluctant to rule in favor of the Cruzans, stating that clear and convincing evidence of what Nancy would have wanted must be presented before a ruling could be made. Three years later, the U.S. Supreme Court heard the case and ruled that the guardians of incompetent patients could ask that treatment be withheld or withdrawn but that states could determine the level of evidence needed to allow such a decision to be acted upon. Eventually, the Cruzans were able to have Nancy's feeding tube removed after three of her friends testified that, prior to her accident, she had specifically told them that she never would have wanted to remain alive in a persistent vegetative state.

During the Cruzan case, Senator John Danforth proposed the Patient Self-Determination Act (PSDA). Implemented in 1991, the PSDA was seen at the time as a large step toward increasing the utilization of advanced directives. The PSDA requires hospitals, medical centers, and nursing homes that receive federal funds (primarily referring to Medicare and Medicaid) to inform all patients, upon admittance to the hospital, of their right to make their end-of-life wishes known in the form of an advanced directive. The goal of this act was to increase public awareness and completion of advance directives. Despite good intentions, the number of individuals completing advance directives has not increased significantly since the inception of the PSDA. Current estimates place the incidence rate of completed advance directives for the general U.S. population somewhere between 15% and 25%.

When Individuals Do Not Have Advance Directives

In general, there are three types of laws that may come into effect when individuals are not competent to make their own decisions: laws regarding (1) living wills, (2) durable power of attorney, or (3) family consent (a.k.a. surrogacy or succession laws). States may have any one or a combination of these three laws in place. Laws regarding living wills and durable power of attorney vary by state but typically set forth guidelines for which advance directives are recognized, when the advanced directive may be applied (e.g., only when the person has been diagnosed with a terminal illness), who is eligible to make decisions for the individual, and how the decision regarding care is made.

Surrogacy or succession laws typically come into play when no written instructions have been set forth by the patient. When this occurs, a family member hierarchy is employed to determine who is eligible to make the end-of-life decisions for the patient. Possible hierarchies differ by state, but one example for an older adult might be spouse, adult children, next closest adult relative, friend of family, and medical professional. Surrogacy or succession laws can be helpful not only when there are no written instructions, but also when more than one medical treatment may meet the criteria set by a patient's advanced directive and the medical doctor wants to know which alternative should be used. Surrogacy or succession laws are also used

when the patient's advanced directive is not entirely clear and needs to be clarified by someone who may know the patient's wishes.

Debate on the Utility of Advance Directives

As research on advance directives continues to accumulate, a number of questions have emerged in the literature, such as to what degree advance directives are utilized and followed, and whether they help to ease the burden experienced by family members. Some research has suggested that families of patients who have an advanced directive feel more involved in the decision-making process and more educated about what to expect near the end of their loved one's life. Studies have found that individuals who are more likely to have an advance directive tend to be older, white, more educated, less likely to have family who can make decisions for them, and more likely to be of higher socioeconomic status and at a higher level of cognitive functioning. Although not discussed in detail in this entry, as Jung Kwak and William Haley have noted, there are significant cultural differences in perceptions and use of advance directives.

Given this research, scholars and the public at large have continuously debated the utility of advance directives. Arguments for and against differ based on the advance directive in question, with some individuals being more in favor of one type over another. Proponents of living wills, for example, argue that this advanced directive offers the individual the most control over the circumstances surrounding his or her death and the most autonomy near the end of life. Opponents argue that it is impossible to predict every scenario that one may face and to provide treatment preferences for every possible end-of-life situation. Furthermore, they point out that individuals change their minds constantly throughout their lives as they gain more life experience. Thus, an individual's living will would have to be routinely updated at least every year to take these changes into consideration.

On the other hand, proponents of the durable power of attorney approach argue that unlike the living will, the designated decision maker can make a decision regarding the specific situation the patient is facing. Opponents, however, point out that the designated proxy may not follow the patient's wishes. For example, a daughter who holds her mother's durable power of attorney may be well aware that her mother never wanted to be put on a feeding tube, but may request that one be inserted because of her personal values or her difficulty accepting the terminality of her mother's condition. Another stated weakness of the durable power of attorney is that the designated proxy may be unaware of the patient's wishes in a given situation and thus may not be able to make an informed decision regarding medical treatment.

Some general problems with advance directives in addition to those already mentioned also exist. First, only a small percentage of the general population has an advance directive in place. Second, legal policies regarding advance directives vary by state. For example, in some states advanced directives apply only when an individual is terminally ill (typically defined as having less than 6 months to live) and do not cover situations where the patient is in a PVS and therefore can "live" in this condition for years. A third problem that expands on this is that many individuals do not fully understand the treatments they specify in their advanced directives. Research has consistently shown that many individuals do not understand how CPR works, what the survival rate of receiving CPR is, and the damage that can be caused to the body in the process. Studies have found that individuals often change their living wills after receiving this information. A final problem is that medical professionals are not routinely involved or consulted in the construction of advance directives. Research has shown that patients fill out advance directives primarily with their lawyer or family and rarely include their physician. This only adds to the problem of misinterpretation of what medical treatments entail and what purpose advance directives serve.

One possible solution to this debate has been the idea of "advance care planning." This approach emphasizes continued discussion between a patient and his or her health care provider that aims to clarify the patient's values and wishes regarding end-of-life care in general, as opposed to the patient stating what he or she would want done in every specific situation possible. This approach can also help incorporate individuals' shifting opinions as they age and transition through different life stages, as well as ensure that the physician is continuously involved in the planning process. Research has even suggested incorporating a

"values history" as part of the routine medical history that is taken in hospital settings, especially for elderly patients. A values history can assess personal values about quality of life, autonomy, family relations/burden, physical comfort and pain management, and treatment philosophy, to name a few. Understanding individuals' life values is important because such values are often associated with the likelihood of completing an advanced directive, as well as a patient's preferences for life-sustaining treatment such as CPR. For example, individuals who value quality of life over a desire to live as long as possible may be less likely to want extensive life-sustaining treatments near the end of life. This approach may even help the patient better understand his or her preferences regarding end-of-life care.

Conclusion

During the 20th century, several court cases and statutes have helped pave the way for incompetent individuals to exert some control over the circumstances surrounding their death. Yet, in spite of reforms that recognize the legal status of advance directives, debate surrounding the utility of these documents remains. At present, only a small proportion of the U.S. population has an advance directive in place, and states differ in their regulations regarding these documents. However, new approaches, such advance care planning, are evolving to address some of the limitations inherent in current advance directive practices. Although much research has been conducted on the utility of advance directives, the results are often mixed or incomplete. More research is needed to determine the approach to end-of-life care and decision making that will best address individuals' diverse preferences and needs near the end of life.

James L. Werth, Jr., Jessica M. Richmond, and Elena Yakunina

See also End-of-Life Decision Making; Legalities of Death; Persistent Vegetative State; Quality of Life; Right-to-Die Movement

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Loved One, The

The Loved One: An Anglo-American Tragedy (1948) is a satirical novel by the English novelist Evelyn Waugh (1903–1966) and is regarded by many critics as one of the best fictional works of the past century. The novel's unabashedly comic treatment of the subject of death and funeral customs was widely accepted by a postwar audience and paved the way for even more adventurous treatments of these themes in literature. *The Loved One* inspired critical examinations of the funeral industry and southern California's famous Forest Lawn Memorial Park in particular. The novel was also a progenitor of the "black humor" of the 1960s, evident in the 1965 film version of the novel.

Background and Summary

During a 1947 visit to California, Waugh made several visits to Glendale's Forest Lawn cemetery, which made an indelible impression. Once back in England, he immediately began work on a satirical novel based on American funeral customs. The novella's principal character is the young English poet Dennis Barlow, a typically bemused and passive Waugh anti-hero. Barlow is lodging in Los Angeles with the elderly expatriate screenwriter Sir Francis Hinsley. After being fired by the studio, Sir Francis commits suicide, leaving Dennis to deal with his remains. He visits the fabled Whispering Glades cemetery and meets the lovely cosmetician Aimée Thanatogenos (her first name comes from the evangelist Aimee Semple McPherson—a resident of Forest Lawn—and her surname means "born of death" in Greek), who introduces him to the various services that the mortuary can provide his "loved one."

Dennis becomes infatuated with Aimée, who seems more "decadent" and therefore more interesting than common American girls. Aimée and Dennis meet in a corner of Whispering Glades, where the girl tells him about how she became a cosmetician and about her love for transforming corpses. His rival is the expert embalmer Mr. Joyboy, known for his ability to put peaceful smiles on faces stiffened by rigor mortis. Dennis, meanwhile, toils away at the ovens of a pet cemetery, the Happier Hunting Ground, where he disposes of animal corpses while writing poetry. Joyboy offers Aimée a chance to become the first female embalmer at the cemetery and takes her home to meet his mother.

Aimée is torn between her admiration for Joyboy's professional skills and her love for Dennis's poetic nature and writes to a newspaper "advice-to-the-lovelorn" columnist, who is in reality the cigar-chewing Mr. Slump. Barlow pitches woo, but the romance comes to a sudden end when Aimée accompanies Mr. Joyboy to his mother's parrot's funeral and finds Dennis at the pet cemetery. She immediately decides to become engaged to the embalmer, and she and Dennis have a final meeting in which he expresses his cynicism about the funeral trade. Mr. Joyboy, on the other hand, proves to be more attached to his mother and her bird than his fiancée, leaving her in a state of agitation. After the advice columnist advises her to take a leap, she decides instead to return to Whispering Glades and commit suicide by taking cyanide and injecting herself with the embalming needle. Worried by the possible damage to his reputation arising from her death, Joyboy agrees to turn Aimée's corpse over for disposal in the animal crematorium, while Dennis cynically accepts hush money from both Joyboy and the expatriates, who pay him to take the next plane back to England.

Analysis and Significance

The Loved One was published in book form first in the United States and later in Britain; despite Waugh's wariness about its reception, both critics and the general public in both countries accepted the more gruesome aspects of the book. Perhaps the horrors of the war had prepared them for such subjects. While so-called dark humor involving the pointless or absurd deaths of characters is characteristic of many British novels of the interwar period (including Waugh's) and has been described as a coping mechanism for dealing with modern life, there are few precedents—Robert Louis Stevenson's *The Wrong Box* is one—for Waugh's relentless use of corpses, embalming, cremation, suicide, and other "black" subjects for comic effect.

Waugh's satire focuses on several targets, including the excesses of postwar American culture, the narcissism of the English expatriates in California, and the phoniness of Hollywood. These all derive from the author's evident disgust with American culture. But the prime object of his satire is the funeral industry, the modern metropolises of death, and their attempts to deny death and the dissolution of the body. For a full understanding of the novel, it is necessary to understand that Waugh had converted to Catholicism in 1928 and that his spiritual outlook informs all of his subsequent fiction. Beginning with *Vile Bodies* (1930), Waugh's novels tend to contrast the materialism of modern life with a worldview founded on the Catholic faith, tradition, and political conservatism. The very notion of "vile bodies," with its biblical allusion to the inevitable corruption of the flesh, suggests the religious underpinnings of Waugh's social satire.

Waugh's most pointed satirical thrusts are reserved for the meretricious physical environment of Whispering Glades. Waugh's own library, now

at the University of Texas at Austin, contains a view book with fulsome descriptions of Forest Lawn's glades, lakes, and parks such as "Slumberland" and "Dawn of Tomorrow." He hardly needed to embellish these at all to achieve a comic effect, and indeed his fictional memorial park is nearly a carbon copy of the real thing. Significantly, Whispering Glades is nestled next to Hollywood, the capital of illusion and artifice. Most of the statues in the park are replicas of well-known classical sculpture and historical figures, yet they exploit the past for commercial gain rather than pay homage to it. History and popular culture absurdly rub shoulders. Throughout the park, superficiality and artifice are the order of the day, reflecting the nightmarish vision of Dr. Wilbur Kenworthy, the "Dreamer," who is based very closely on the real founder of Forest Lawn, Dr. Hubert Eaton, known as the "Builder." Like Eaton, Kenworthy (who does not actually appear in the book) has sanitized death by placing his cemetery in the midst of a pleasant park-like atmosphere, with fountains, tall trees, and statuary. Moreover, Kenworthy, like Eaton, was an innovator in locating his funeral home in the cemetery itself and employing a host of marketing schemes to persuade vulnerable relatives that their "loved ones" required more expensive caskets and arrangements. Waugh also satirizes Eaton's euphemistically named "pre-need planning," an innovation designed to sell overpriced funeral packages to the living.

The novel continually moves back and forth between the sordid realities of death—for example, Sir Francis's hanged body with its lolling black tongue—and the hygienic embalming room and antiseptic viewing rooms of Whispering Glades. Aimee's cosmetology and Mr. Joyboy's efforts to resculpt the gruesome expressions on dead faces are attempts to cover over the horror of death and result in an "obscene travesty." Callous and venal though he is, Mr. Schultz, the cynical owner of the Happier Hunting Ground pet cemetery, at least acknowledges the actuality of death and is not interested in covering over the stench of death with the cloying aroma of disinfectant.

Influence

A decade and a half after its publication, Waugh's novel had a major influence on Jessica Mitford's celebrated investigative book *The American Way of Death* (1963), later revised as *The American Way of Death Revisited* (1989). Mitford was a member of the well-known English clan closely associated with Waugh (her sister Nancy was one of his most faithful correspondents and the dedicatee of *The Loved One*). It was Waugh who surely inspired Mitford's coolly ironic descriptions of Forest Lawn, its phony classical statuary, its canned music, sanitized parlors, and the contrasts between the venality of its "funeral directors" (i.e., morticians) and their smarmy empathy for the bereaved. One of the principal themes shared by both books is the use of euphemistic language to cover up the unpleasant realities of death and loss. Nancy Mitford (1996, p. 458) wrote to Waugh that Jessica's book was in effect "a factual *Loved One*." The exposé was widely reviewed, became a best seller, and made the author an instant celebrity. Waugh himself gave *The American Way of Death* a generally favorable notice, praising its humor, but referred to the lack of "a plainly stated attitude to death."

In 1965, *The Loved One* became a feature film directed by Tony Richardson and starring Robert Morse as Dennis Barlow and Anjanette Comer as Aimée. The screenplay by Terry Southern (with contributions by Christopher Isherwood) pushed the envelope of what was acceptable in a Hollywood film and was advertised as "the motion picture with something to offend everyone," although it now seems rather tame. Eschewing Waugh's dry, spare wit, Southern's adaptation put more emphasis on sexual innuendo, the macabre, and the dark side of the funeral industry. He added several elements not in the original novel, including a grotesque eating scene at Mrs. Joyboy's house and an unctuous casket salesman played by Liberace. A new plot line, involving Dr. Kenworthy's brother and corpses being rocketed into outer space, reflects the intersection of death and the space age. Richardson's direction stressed broad physical comedy and encouraged overplaying (not that Jonathan Winters, with a memorable role as Dr. Kenworthy, the sinister "Dreamer" behind Whispering Glades, needed any encouragement). The result was a movie that was unsatisfactory to most devotees of the book, although it achieved minor cult status and has been re-released on DVD. It also inspired an episode of the BBC (British Broadcasting Corporation) series *Dr. Who*.

In regard to its black humor and treatment of death, the film should be paired with Southern's nearly contemporaneous *Dr. Strangelove* (1964). Both movies attempted to shock moviegoers—*The Loved One*, with its violation of various taboos concerning death and funeral customs, and *Dr. Strangelove,* with its attack on the folly of "mutually assured destruction." The latter features an apocalyptic ending with an accidental nuclear holocaust set ironically against the World War II tune "We'll Meet Again." Both films reflect an increasing acceptance of what would be known as "black humor" or "black comedy," which features ostensibly serious subjects not formerly associated with humor, such as cremation or mass nuclear annihilation. Significantly, Bruce J. Friedman's seminal anthology *Black Humor* appeared in 1965, the same year as the filmed version of *The Loved One*. Both films and black humor in general are recognizable as responses to traumatic events of the early 1960s, including the Cuban Missile Crisis and the Kennedy assassination, which made the unthinkable suddenly thinkable. Black humor can also be regarded as a pushing from a Freudian perspective. Black humor provides a way for the subconscious to deal with the prospect of its own annihilation, which became a very real prospect in this era.

Waugh's small satiric masterpiece remains remarkably fresh and relevant today, a useful antidote for the persistent mortician-speak of "preneed planning" and "loved ones" that may still be found in advertising for funeral homes and cemeteries, including Forest Lawn's web pages. The novel retains its ability to startle and usefully reminds one that death *can* be a laughing matter.

Richard W. Oram

See also Funeral Industry; Humor and Fear of Death; Language of Death; Literary Depictions of Death; Suicide

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Lynching and Vigilante Justice

Lynching, also referred to as lynch law and Lynch's law, is the illegal execution by a mob of a person suspected of a crime or some other prohibited behavior. Lynching is today a felony in the United States. A separate felony category is second degree lynching (an attempted execution by a mob where the victim survives). The method of execution most frequently associated with lynching is hanging, but that has not always been the case. The law now includes any mob action that could result in death.

Origins of the Concepts

The concept of lynching appears to have started as a reference to executions ordered by Charles Lynch in 1780. Lynch was a militia officer in America's War of Independence and a justice of the peace. He joined with other officers to try men suspected of disloyalty to the new American nation in an unofficial court of their own creation. Executions were ordered and carried out, along with whipping, seizure of property, forced loyalty oaths, and service in the military for those who were not executed. The victims of these summary executions were Tories who maintained loyalty to England. The actions of Lynch and his companions were legitimized when the Virginia General Assembly later approved their actions in 1782. It was these executions that forever linked the name Lynch and the term *lynching* to the concept of vigilante justice.

The term *lynching* originated in the eastern part of the United States. The term *vigilante* originated in the U.S. Southwest. The word *vigilante* comes

from the Latin *vigilans,* meaning "to watch." In Spanish and Portuguese the term *vigilante* means a "watchman." Unlike someone who commits a lynching, a vigilante is not necessarily a criminal. Vigilante conduct is officially disapproved because of its potential to yield to criminal behavior by the vigilante. Neither "lynch justice" nor "vigilante justice" is held by any recognized authority to be either legal or just.

Political Reaction to the Term *Lynching*

Although it originally had no racial component, the term *lynching* has come to describe crimes against African Americans. The special connection between lynching and race began in reference to the murders of both blacks and of abolitionists in the 1830s. In St. Louis in 1836, Elijah Lovejoy published an account of the lynching of an African American man. He also reported on the trial and acquittal of the killers. His report so angered opponents to abolition that his press was destroyed by a white mob. When Lovejoy secured a new press, it was also destroyed and Lovejoy was shot and killed. The motivating factor in both deaths was opposition to freedom for blacks.

After the Civil War, the Ku Klux Klan began widespread use of lynching and the threat of lynching to try to maintain white supremacy in the post–Civil War South. According to statistics from the Tuskegee Institute, 1886 was the first year in which the number of African Americans lynched exceeded that of whites (although blacks comprised a far smaller percentage of the overall population).

One of the first investigations into lynching was carried out by the editor of a Memphis newspaper, Ida Wells. In 1884 she discovered that during one period 728 black men and women had been lynched by white mobs. Of these deaths, two thirds were for small offenses such as public drunkenness or shoplifting. Lynch law was changing, now being applied based on the race of the alleged offender. When, in March 1892, three African American businessmen were lynched in Memphis, Wells published a condemnation of the murderers and referred to them as lynchers. In response to her article, a white mob destroyed her printing press. At that time the leaders of the mob stated they intended that Wells would share the earlier fate of Elijah Lovejoy, but she was away from Memphis on a trip when the attack occurred.

Continued threats on her life made it necessary for her to relocate and she took a position with the newspaper, *New York Age*. There she continued her campaign against lynching and its legal counterpart, Jim Crow laws (legislation passed to prevent blacks from exercising their rights, especially the right to vote).

One of the earliest black politicians to speak out against lynching was George Henry White, the last former slave to serve in Congress and, at that time, the only African American in the House of Representatives. In January 1901, Congressman White proposed the first bill to make lynching a federal crime. He argued that any person participating in, or acting as an accessory to, a lynching should be convicted of treason. White pointed out that lynching was being used by white mobs in the South to subjugate African Americans. He showed that 87 of the people lynched in 1899 were African Americans (80% of all lynchings). In spite of White's efforts and evidence, the bill was defeated.

Extent of the Crime

The exact number of lynching victims may never be known. There is disagreement among sources. However, the most commonly cited figures of numbers of people killed by lynching come from the Archives of Tuskegee Institute. The institute was founded in 1881 with Booker T. Washington as its first teacher. From its founding, the institute, now part of Tuskegee University in Tuskegee, Alabama, compiled data on lynchings based on newspaper accounts and letters from across the United States. The figures from the Tuskegee Institute shown in the tables are telling; of the 4,743 lynching deaths unofficially recorded for the period 1886 through 1964 and shown in the Tuskegee Institute archives, 73% victims were black.

The NAACP Fight Against Lynching

Almost 2 decades after Congressman White's bill was defeated, the fight for antilynching legislation was picked up by the National Association for the Advancement of Colored People (NAACP). The NAACP fought a long campaign against lynching

Table 1 Lynchings: By Year and Race

Year	*Whites*	*Blacks*	*Total*	*Year*	*Whites*	*Blacks*	*Total*
1882	64	49	113	1926	7	23	30
1883	77	53	130	1927	0	16	16
1884	160	51	211	1928	1	10	11
1885	110	74	184	1929	3	7	10
1886	64	74	138	1930	1	20	21
1887	50	70	120	1931	1	12	13
1888	68	69	137	1932	2	6	8
1889	76	94	170	1933	2	24	26
1890	11	85	96	1934	0	15	15
1891	71	113	184	1935	2	18	20
1892	69	161	230	1936	0	8	8
1893	34	118	152	1937	0	8	8
1894	58	134	192	1938	0	6	6
1895	66	113	179	1939	1	2	3
1896	45	78	123	1940	1	4	5
1897	35	123	158	1941	0	4	4
1898	19	101	120	1942	0	6	6
1899	21	85	106	1943	0	3	3
1900	9	106	115	1944	0	2	2
1901	25	105	130	1945	0	1	1
1902	7	85	92	1946	0	6	6
1903	15	84	99	1947	0	1	1
1904	7	76	83	1948	1	1	2
1905	5	57	62	1949	0	3	3
1906	3	62	65	1950	1	1	2
1907	3	58	61	1951	0	1	1
1908	8	89	97	1952	0	0	0
1909	13	69	82	1953	0	0	0
1910	9	67	76	1954	0	0	0
1911	7	60	67	1955	0	3	3
1912	2	62	64	1956	0	0	0
1913	1	51	52	1957	1	0	1
1914	4	51	55	1958	0	0	0
1915	13	56	69	1959	0	1	1
1916	4	50	54	1960	0	0	0
1917	2	36	38	1961	0	1	1
1918	4	60	64	1962	0	0	0
1919	7	76	83	1963	0	1	1
1920	8	53	61	1964	2	1	3
1921	5	59	64	1965	0	0	0
1922	6	51	57	1966	0	0	0
1923	4	29	33	1967	0	0	0
1924	0	16	16	1968	0	0	0
1925	0	17	17	**Total**	**1,297**	**3,445**	**4,742**

Source: Unofficial statistics provided by the Tuskegee Institute Archives.

Table 2 Lynchings: By State and Race, 1882–1968

State	*White*	*Black*	*Total*
Alabama	48	299	347
Arizona	31	0	31
Arkansas	58	226	284
California	41	2	43
Colorado	65	3	68
Delaware	0	1	1
Florida	25	257	282
Georgia	39	492	531
Idaho	20	0	20
Illinois	15	19	34
Indiana	33	14	47
Iowa	17	2	19
Kansas	35	19	54
Kentucky	63	142	205
Louisiana	56	335	391
Maine	1	0	1
Maryland	2	27	29
Michigan	7	1	8
Minnesota	5	4	9
Mississippi	42	539	581
Missouri	53	69	122
Montana	82	2	84
Nebraska	52	5	57
Nevada	6	0	6
New Jersey	1	1	2
New Mexico	33	3	36
New York	1	1	2
North Carolina	15	86	101
North Dakota	13	3	16
Ohio	10	16	26
Oklahoma	82	40	122
Oregon	20	1	21
Pennsylvania	2	6	8
South Carolina	4	156	160
South Dakota	27	0	27
Tennessee	47	204	251
Texas	141	352	493
Utah	6	2	8
Vermont	1	0	1
Virginia	17	83	100
Washington	25	1	26
West Virginia	20	28	48
Wisconsin	6	0	6
Wyoming	30	5	35
Total	**1,297**	**3,446***	**4,743***

Source: Unofficial statistics provided by the Tuskegee Institute Archives.

* The slight discrepancy in totals between Tables of the State and Race, and Year and Race is not a typographical error; it derives from the complexities of recording mob action.

Table 3 Causes of Lynchings, 1882–1968

	Number	*Percentage*
Homicides	1,937	40.84
Felonious Assault	205	4.32
Rape	912	19.22
Attempted Rape	288	6.07
Robbery and Theft	232	4.89
Insult to White Person	85	1.79
All Other Causes	1,084	22.85
Total	**4,743**	**100.00**

and tried to educate Americans and others about the nature of this practice. In 1919, the NAACP published *Thirty Years of Lynching in the United States: 1889–1918*, and it placed paid advertisements in newspapers across the United States to present facts about lynching.

A decline in lynching occurred during World War I, but in the year after the war ended, more than 70 blacks were lynched. Ten black soldiers, several still in their army uniforms, were among those murdered. Some had served in the most highly decorated unit in the American Expeditionary Force in World War I. In the postwar years of 1919 to 1922, 239 blacks were lynched by white mobs. More were killed by individual acts of violence and in lynchings that were never recorded. Not one white person was punished for these hundreds of crimes.

Some whites were also lynched during these years, for example, the leaders of trade unions, including Frank Little and Wesley Everest, two members of the Industrial Workers of the World. These killings might be seen as examples of vigilante justice, since they were used by those who were watching out for dangers to the United States at home and abroad. However, they can be seen as lynching because they mirrored in many ways the executions ordered by Charles Lynch to punish "enemies" of his country.

"Strange Fruit"

The jazz song "Strange Fruit" has come to be considered an anthem of the antilynching movement. In 1937, a New York schoolteacher saw a photograph of the lynching of Thomas Shipp and Abram

Smith. The teacher, Abel Meeropol, later said that the photograph haunted him and that it inspired him to write the poem "Strange Fruit." Meeropol, using a pen name, Lewis Allan, published the poem in the *New York Teacher.*

After seeing Billie Holiday perform in New York, Meeropol showed her his poem. Holiday liked it and turned it into the song "Strange Fruit." The record was popular in 1939, but the song was denounced by *Time* magazine as "a prime piece of musical propaganda" for the NAACP. But the original photograph of the lynching of Shipp and Smith, along with the poem and song that the picture inspired, played a role in creating greater opposition to lynching in the United States.

The Michael Donald Case: NAACP Versus the Klan

In 1981 Josephus Andersonan, an African American, was brought to trial in Mobile, Alabama, charged with the murder of a white policeman. The jury could not agree on a verdict. Some members of the Ku Klux Klan believed that this was because some members of the jury were African Americans. At a meeting held after the trial, Bennie Hays, an official of the Klan in Alabama, is said to have declared that if a black man can get away with killing a white man, a white man ought to be able to get away with killing a black man.

On March 21, Henry Hays, son of the Klan official, and James Knowles decided they would exact justice themselves for the failure of the courts to convict the murderer of a policeman. The pair drove around Mobile and saw a young black man, Michael Donald, walking home. They forced 19-year-old Donald into their car, drove him to the next county, and lynched him. After a brief investigation, the local police announced that Donald had been murdered as a result of a disagreement over drugs. Donald's mother, Beulah Mae Donald, knew her son had never been involved with illegal drugs and decided to fight for justice. She contacted Jesse Jackson, who came to Mobile and led a march to protest the police investigation, which appeared either haphazard or, at worst, part of a conspiracy.

Agent James Bodman of the Federal Bureau of Investigation was able to persuade James Knowles to confess to the killing of Michael Donald. In June 1983, Knowles was found guilty of violating Donald's civil rights and was sentenced to life imprisonment. Six months later, when Henry Hays was tried for murder, Knowles appeared as the chief prosecution witness. Hays was found guilty and sentenced to death.

The Southern Poverty Law Center convinced Beulah Mae Donald that her case could destroy the Ku Klux Klan in Alabama. Her civil suit against the United Klans of America reached the court in February 1987. The all-white jury found the Klan responsible for the lynching of Michael Donald and ordered it to pay $7 million. This caused the Klan to surrender its national headquarters in Tuscaloosa County, Alabama. When Henry Hays was executed in June 1997, it was the first time a white man had been executed for a crime against an African American since 1913.

Reinterpretation of Lynching

The term *lynching* had taken on a new meaning, almost exclusively racial, by the beginning of the 21st century. It was seen by some as any unjust accusation or attack against an African American. In October 1991, at his confirmation hearings, Supreme Court nominee Clarence Thomas was questioned about his alleged sexual harassment of a staff member of his office. It appeared that he might not secure Senate confirmation of his appointment to the Supreme Court. In a passionate statement, Thomas referred to the attacks on his character by the predominantly white Senate committee as an example of a "high tech lynching." The passion aroused by that statement helped to hasten his confirmation.

In January 2008, for using the term *lynching*, sports reporter Kelly Tilghman was suspended from her position for 2 weeks. In speaking about the dominance of a minority golfer, she said that young players wanted to "lynch him in a back alley." At the time, in calling for her to be censured, one civil rights activist said that the term *lynch* was offensive to all blacks. His comments, limiting the term to blacks, demonstrate that the meaning and application of a word can change over time, for social or political reasons.

Vigilante Justice

Vigilante justice in the southwestern United States was most often applied by a posse who pursued

suspected wrongdoers and, after catching them, handed out their own justice. The scene has become part of American culture through novels, films, and television. The men who formed the posse were often sworn in, with authority much like that claimed by Charles Lynch. They watched for threats to citizens, their property, and the law. However, when they abandoned their charge to bring the accused lawbreakers back for trial and carried out their own sentence and executed prisoners, they crossed a line by breaking the law themselves.

Vigilantes, unlike the mobs who lynched those said to have violated some rule of behavior, at least appeared to have the trappings of a court. There was often some form of hearing where the accused offered a defense. During the California Gold Rush of 1849, an increase in crime and violence in San Francisco led to the creation of a vigilance committee. The committee consisted of 600 local volunteers, chiefly prominent citizens. In 1851, the committee hanged 4 men, had 1 whipped, and deported 20 others. However, they also found over 40 not guilty and released them after their "trial." This committee was disbanded after a year because there had been a major decline in violence and crime. The remoteness of mining camps put their residents outside of any official legal authority. To try to prevent chaos, communities often established a vigilance committee and gave this group the combined roles of jury, judge, and executioner. When law enforcement officers arrived, vigilance committees were typically abandoned.

An example of modern vigilantes who offer security and keep watch for lawbreakers can be seen in the "Guardian Angels." This organization was founded in New York City by Curtis Sliwa in 1979. The Guardian Angels now have chapters in cities throughout the United States and abroad. However, in spite of the positive record of the Guardian Angels, there remains in vigilantism the potential to cross the line and to become judges and executioners.

There are those today who defend vigilantes and their role. Indeed, some analysts argue there may be a role again for community vigilantes. Such a case may have been the death in 1980 of a town bully who was shot to death as he sat in his truck in Skidmore, Missouri. The victim seemed to be the modern embodiment of the desperados that vigilance committees were intended to apprehend in the Old West. He had been accused of molesting young girls, rustling livestock, stealing grain, and burglarizing farmhouses. These alleged crimes took place in four states, but the accused escaped conviction by intimidating witnesses and even law enforcement officers.

The entire town of Skidmore lived in fear. Whoever crossed the town bully risked receiving intimidating phone calls, night visits, even death threats. The people believed that the bully might well be above the law. The murder was never solved and may have been a case of the town carrying out modern vigilante justice.

The Minuteman Project

A more recent vigilante group is the Minuteman Project. The Minuteman Project was started April 2005 by private citizens to "watch" the U.S.–Mexico border. Their intent was to report on and to lessen the flow of illegal immigrants into the United States. The founder of the group named it for the Massachusetts militiamen who fought in the American Revolution. The members describe themselves as "a citizens' Neighborhood Watch on our border." They have attracted attention to the issue of illegal immigration. The Minutemen also have aroused strong emotions among opponents and supporters.

Opponents have said the Minutemen associate with neo-Nazis and skinheads, but no actual link has been proven. The Mexican and U.S. presidents have expressed their distrust for vigilante group actions on the U.S.–Mexico border. But the worst problem known to have been caused by Minutemen was the accidental tripping of sensors along the American side of the U.S.–Mexico border.

Supporters have praised the work of the Minutemen. The governor of California, Arnold Schwarzenegger, said he welcomed minuteman patrols on the California–Mexico border. Supporters applaud their efforts to help the border patrol and feel their protests are merely legitimate expression protected by their right to freedom of expression. Opponents protest the actions and protests staged by the Minutemen. These mixed reactions illustrate the mixed feelings found among Americans who believe that official channels may

not be effective in keeping watch over U.S. borders in these difficult times.

Robert G. Stevenson

See also Capital Punishment; Hate Crimes and Death Threats; Homicide

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Make-A-Wish Foundation

The Make-A-Wish Foundation is one of several foundations that grants wishes to children with life-threatening conditions. It is a nonprofit organization that brightens the lives of gravely ill children by fulfilling their wishes to go, be, meet, or have whatever they have wished for. The largest wish-granting organization in the world, the foundation has helped over 148,000 children by funding vacations, career explorations, celebrity interactions, and gifts, among other wishes. Founded in 1980, it operates 69 chapters in the United States and its territories and runs a global affiliate called Make-A-Wish International.

The foundation is an outgrowth of the Chris Greicius Make-A-Wish Memorial, the fund established in memory of a terminally ill boy who received his wish to become a police officer after being named an honorary member of the Arizona Department of Public Safety. Greicius's mother, Linda Bergendahl-Pauling, and two police officers who were active in this initial wish granting effort, Frank Shankwitz and Scott Stahl, along with Kathy McMorris and Allan Schmidt, cofounded the Memorial and spearheaded its transformation into the foundation.

When granting wishes, the foundation uses a four-step process. First, the candidate is referred by a medical professional, parent, or legal guardian, or is self-nominated. Candidates must be between the ages of 2 and a half and 18 years old in order to be eligible for a wish. Second, the severity of the child's condition is assessed to determine if it is sufficiently life threatening. Potential wish children must have a degenerative, progressive, or malignant medical condition but it need not be terminal. Third, one of the foundation's 25,000 volunteers is deployed to assist the child in developing a wish. These volunteers help wish children search their imaginations for something that will bring them happiness. Finally, the child's wish is implemented. Though many wish children are "terminal" or "dying," the foundation does not use these words in its interactions and actively de-emphasizes the mention of illness and clinical treatments.

The philosophy of the foundation is to better the human experience by bringing strength, hope, and joy to wish children, their families, and their supporters. It enacts this philosophy by providing wish children and their families with a temporary retreat from the harsh realities of serious illness and by involving donors, communities, volunteers, and sponsors in these life-changing efforts.

Funding, Supporters, and Operations

Make-A-Wish covers all expenses associated with the granting of a wish, including those tied to family member participation. With more than 78% of every donated dollar devoted to wish granting, the majority of the foundation's incoming funds are directly applied to these altruistic expenditures. This proportion of charitable pass-through is above the threshold set by the Council of Better Business Bureaus' Wise Giving Alliance, indicating

that the foundation exceeds this watchdog organization's program service standards. On average, a wish costs $6,450 and is granted without regard to socioeconomic status, race, or gender. These funds are often devoted to one of the following wishes: visiting a Disney theme park (41.5%), traveling (19.3%), going on a shopping spree (10.9%), receiving a new computer/electronics (8.7%), and interacting with a celebrity (6.1%). Make-A-Wish estimates that it grants a wish every 41 minutes.

The foundation's first wish child was Frank Salazar, a 7-year-old with dreams of becoming a firefighter. Prior to his death, the foundation arranged for Salazar to become an honorary member of Phoenix Arizona's Fire Department and organized his visit to its firehouse. Media attention surrounding this wish prompted community and corporate involvement in the foundation's efforts. As a result, Salazar gained a hot air balloon ride and a trip to the Disneyland theme park; the foundation won public recognition and the advocacy of the Walt Disney Company.

Disney has remained one of the foundation's primary supporters and it is currently among the organization's largest financial donors. The foundation enjoys similar levels of monetary support from Macy's and also earns sizable annual contributions from American Airlines, Delta Airlines, U.S. Airways, General Motors, Avis Rent A Car, UnitedHealth Group, and Things Remembered. Corporate donations are named by four categories of annual giving: Mission Champions are at $5 million and over, Wish Champions are at $1.5 million and over, Cause Champions are at $500,000 and over, and Fund Raising Advocates are at $250,000 and over. The foundation also has Promotional Supporters, entities that provide $500,000 or more in advertising and awareness contributions, and Corporate Donors, firms that give products or services to Make-A-Wish.

In addition to corporate support, the foundation relies on individual contributors to achieve its mission. Such individuals often assist by making financial contributions through monthly giving, estate planning, and honor, memorial, or general donations. Individual donors are similarly invited to give in-kind items, frequent flier miles, and hotel reward points or shop at the foundation's online auctions, the Make-A-Wish Store, or one of the organization's partner retailers. The foundation also welcomes the human resources of those willing to lend their time and talents to its wish granting mission. These volunteer efforts may involve being one of the foundation's staff volunteers or helping organize a local event that raises funds and awareness for Make-A-Wish. Awareness is also cultivated by individuals who purchase a Wish Star, a magnetic symbol of support for the foundation's goals.

The monies received from corporate and individual donations represent the largest source of the foundation's annual revenues of approximately $180 million. These funds are put to use by a management team based at the Make-A-Wish headquarters in Phoenix, Arizona. This team is accountable to the foundation's National Board of Directors. The management team also receives guidance from Make-A-Wish's National Advisory Council, a coalition of influential individuals and celebrities that stimulate awareness and support for the foundation.

Ryan McDonald

See also Adolescence and Death; Childhood, Children, and Death; Pediatric Palliative Care; Terminal Care; Terminal Illness and Imminent Death

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Malthusian Theory of Population Growth

The Malthusian theory of population growth addresses the ability of the human species to

increase in population size and to eventually reproduce itself beyond its own ability to grow enough food to sustain this ever-expanding population size within the limits of a defined habitat. Population growth is exponential, while the ability of Homo sapiens to grow food is arithmetic. The consequences of this imbalance in population growth and available food supply would, according to Malthus, either be corrected through human intervention resulting in maintaining an appropriate balance between population size and available food equilibrium or the population would be reduced in size through consequences that include disease, epidemics, famine, and war. In the following text, the authors address the utility of the Malthusian theory by applying its basic tenets to population issues.

Malthus's Principle of Population

Thomas Robert Malthus was born in England in 1766. He was educated at Jesus College in Cambridge. At the age of 22, he became a curate near his family home in Surrey and later in Lincolnshire. In 1805, he was appointed a professor of history and political economy at East India College, Hailerbury, a position he occupied until his death in 1834.

It was during his early years as a rural clergyman when, at age 32, he published anonymously the first edition of his famous work, *An Essay on the Principle of Population as It Affects the Future Improvement of Society, with Remarks on the Speculations of Mr. Goodwin, Mr. Condorcet, and Other Writers* (1798). This was mainly a deductive book of around 55,000 words, whereas the second edition expanded his theory and provided a great deal of illustrative data, resulting in around 200,000 words. Subsequent editions, ending in the seventh edition published posthumously in 1872, included relatively minor changes.

Malthus's main argument was that the growth of a population results from the natural urge to reproduce. But material resources, such as food and shelter, cannot keep pace with this growth in human population because these material resources increase at an arithmetic rate (1–2–3–4–5–6–7), while population growth occurs at a geometric rate (1–2–4–8–16–32–64–128). If unchecked, population levels would double in size about every 25 years. Because productive capacity can never maintain this rate for long, the growth in population must be continually checked. Malthus based this estimate on observations of actual population growth in the New World, where resources were once abundant for the relatively small population size. Assuming an initial quantity of 1 unit, in 225 years, the population would be at 512 billion—billions more than at time 1. Yet in that same time period, the means of subsistence would only have increased by 10. In 2,000 years, the difference between population and production would almost be incalculable.

Malthus argued that population growth was held in check in two ways, by preventive checks and by positive checks. The major preventive check was moral restraint, such as the postponement of marriage and abstinence from sexual activity. The positive checks included wars, famine, pestilence, and other forms of misery. If the population was left unchecked, it would grow much faster than material resources and lead to human misery, ultimately resulting in poverty. The checks were divided into two subgroups including misery and vice. Misery included things such as hunger, poverty, and disease, and vice included prostitution, venereal disease, homosexuality, and abortion.

Later Editions of the Principle of Population

In 1803, Malthus published the second edition of his essay, this time under his name, with a different subtitle, namely, *or a View of Its Past and Present Effects on Human Happiness; With an Inquiry Into our Prospects Respecting the Future Removal or Mitigation of the Evils Which It Occasions*. Malthus's second edition of the essay was written as a result of his travels in search of ethnographic and statistical evidence to support his principle of population. In this essay, he focused more on moral restraint as a means to limit the number of births. In addition to the theory of progress, his second essay was also concerned with questions of practice. Under the assumption that the principle of population was thought to be a natural law, Malthus wanted to see if human action could remove or limit its evil effects. Focus was also introduced here on moral restraint; that is, the postponement of marriage until an individual had

prospects for supporting a family. Malthus believed that the only way to avoid the brutal forces of misery and vice was through moral restraint. Although little changed in Malthus's later writings and revisions of the *Principle of Population,* he did note that humans have the ability to control their actions more than population growth is a natural power.

The Theory of Population in Modern Day

Malthus's essay brought into controversy the idea of human perfectibility, which was a prominent ideology in the wake of the French Revolution. Malthus sought to espouse notions of human perfectibility because his beliefs were that scarcity would occur because of overpopulation. His theory opposed two influential schools of thought, mercantilism and utopianism. Malthus's theory was based on two assumptions. He believed that food was necessary for the existence of man and that the passion that exists between the sexes is necessary and will remain at its current state. His theory addresses the consequences on the human population when food and other forms of sustenance are inadequate to sustain a population within its habitat.

The problem is that if human population growth goes unchecked, it will grow faster than the earth can produce subsistence for. Malthus believed that the two powers, subsistence and the growth of the human population, must be kept in balance. In order to keep this balance, misery occurs due to the power of the population to overwhelm resources. Malthus further explained that misery does not fall evenly on all sections of a population, but mostly on the poor.

Several important historical and contemporary examples would appear to support, at least in part, Malthus's claim. Such examples are the Irish potato blight of the 1845 to 1847, the famines of Africa, overpopulation in China, India's lack of an adequate and safe water supply, the U.S. corn epidemic of 1970, and the unprecedented population growth in developing countries.

The main form of sustenance for the population of Ireland in the early 1800s was the potato. In the years 1845 and 1846, the potato crops failed resulting in a great famine. More than 1 million people died and, over the course of the next 5 years, more than 2 million people emigrated. Within a decade, the population of Ireland declined from more than 8 million people to less than 6 million. The crops were also affected in the United States, Canada, and around Europe in those years, but these countries were not as affected. Because Ireland was overpopulated and the farmers were forced to export other crops, such as corn, wheat, barley, and oats, potatoes were the only remaining subsistence for the majority of the Irish people. Although other countries were able to turn to other sources for food, the Irish did not have enough nutritious food to support their population, which resulted in death and emigration.

In sub-Saharan Africa, evidence of positive checks on the population includes drought, poverty, and a shortage of land, which limits food production. AIDS is also reducing life expectancy in many African countries. These factors, as well as the great famines occurring in the 20th century, have reduced the total population. Famines have occurred in Nigeria in 1968 to 1969; West African Sahel in 1969 to 1974; Ethiopia in 1972 to 1974, 1983 to 1984, and 1989 to 1990; Angolia in 1974 to 1976 and 1993 to 1994; Mozambique in 1985 to 1986; Sudan in 1984, 1988, 1993, and 1998; and Somalia in 1984, 1988, and 1992. Many of these famines occurred because of poor rainfall and crop failure, like in the West African Sahel and Ethiopia. For other countries, food supplies were barely adequate but became scarce when wars caused more disruption.

China is a good example of expediential growth that leads to overpopulation of a human habitat. China is the most populous nation in the world, reporting a population in 2008 of over 1.3 billion. China represents more than one-fifth of the human race. In 1959 and 1960, China experienced an estimated 30 million deaths due to starvation and disease, or positive checks that resulted from an economic calamity caused by economic policy and natural disasters. Although China did experience positive checks during this time, preventive checks may be more apparent recently. Malthus argued that preventive checks were the most influential in the Western world and positive checks in the rest of the world, especially in China.

Other evidence of Malthus's argument includes the increasing population of the developing world.

Two-thirds of the world population lives in developing countries. By the end of the 21st century, three-fourths of the population are projected to be living in developing countries. However, there is doubt that food production will be able to keep up with this population growth. The scarcity of fresh water to sustain a growing population could also be a positive check. India, for example, is drawing underground water at twice the rate of recharge. More than half of India's food comes from irrigated land, and many of its children are undernourished.

The Malthusian Legacy

Malthus's essays have sparked much debate. Today, scholars are still debating Malthus's ideas. Many nonbelievers note that Malthus's arithmetic analysis is faulty. However, Malthus always held that population growth was greater than subsistence.

Despite such debate, Malthus did influence many scholars, including Charles Darwin, Herbert Spencer, David Ricardo, and John Maynard Keynes, among many other analysts of the day. One illustration of this influence is a statement attributed to Charles Darwin in his *Autobiography:*

> Fifteen months after I had begun my systematic enquiry, I happened to read for amusement Malthus on population, and being well prepared to appreciate the struggle for existence which everywhere goes on from long-continued observation of the habits of animals and plants, it at once struck me that under these circumstances favorable variations would tend to be preserved and unfavorable ones be destroyed. The result of this would be a new species. Here, then, I had at last got a theory by which to work.

Dudley L. Poston Jr., Bethany S. DeSalvo, and Leslie D. Meyer

See also Demographic Transition Model; Disasters, Man-Made; Disasters, Natural; Famine; Infant Mortality

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MANSLAUGHTER

The crime of manslaughter has evolved over the centuries from a mitigation of murder to crimes committed under levels of criminal culpability. The offense of manslaughter in some states can be defined as the reckless or criminal negligent killing of a human being. Recklessness involves the conscious disregard of gross risks of harm that law abiding or reasonable people will attempt to avoid. Criminal negligence involves the unconscious creation of a risk of harm that is a gross deviation from the conduct of a reasonable person. It is sometimes difficult to determine if a person committed a reckless or a negligent killing.

Brief Historical Background

The criminal law is intended to protect the public good and to deter crime by imposing punishment for wrongdoing. During the Middle Ages, English customs and mores that were based upon Judeo-Christian teachings made it wrong to kill another person. These killings could be avenged by the victim's family, and blood feuds ensued when families disputed the culpability owed to one family by another. From the year 1066, when William I became the first King of England and for several centuries thereafter, the English crown formalized the law by making individual wrongs a crime against the crown. Thus, it came to be the aggrieved party and punishments were to be meted out in the name of the king. Most offenses, including homicide, were deemed felony offenses that were punishable by death. Because someone was killed, however, did not mean in a technical sense

that a crime was committed. Two categories of killing were distinguishable up through the 16th century, criminal homicide (or murder) and justified homicide. Murder was defined as the unlawful taking of another person's life without justification. But one would not be punished by law if the killing occurred in self-defense.

By the 17th century, the criminal law was sufficiently developed that criminal homicides were distinguished into the categories of murder and manslaughter. During this time period, use of the death penalty began to be placed under intense scrutiny. In response, common laws were created to distinguish felonies by taking into consideration the mental state (mens rea) of the accused. Murder, denoted as the killing of a human being with malice, was mitigated to a charge of manslaughter if the act could be demonstrated to have occurred without malice. Rather, the loss of life occurred because the accused acted from the heat of passion or provocation by the victim. This distinction between murder and manslaughter is basic to the present day.

Common Law and Heat of Passion Killings

Unlawful killings at common law were categorized as murder unless the defendant could show that the offense was committed under the heat of passion and was provoked by the victim. But provocation, it was held, had to be so intense that the offender could not control his or her behavior and acted in response to such provocation. In addition, the killing had to occur while the offender's passions were aroused. If a reasonable amount of time were to transpire to allow the perpetrator to become calm, the offense would not be mitigated and the offender would be tried in criminal court for murder and, if found guilty, sentenced to death. If tried and convicted of manslaughter, the sentence was for one year of imprisonment and with the thumb of the perpetrator branded as a signal to the public that punishment had been meted out. In the latter instance, provocation had to be proven and be directly tied to the event at the time the killing took place.

The common law recognized four types of adequate provocation. First, the crime of murder could be mitigated to a manslaughter charge if a man killed his wife while found in the act of adultery. Initially, the mitigation rules applied only to the killing of a wife, but common law cases extended the principle to the killing of a wife's paramour by the enraged husband. The law did not initially recognize such mitigation if a wife found her husband in a similar adulterous act. This killing was categorized as murder. Second, use of force in self-defense (imperfect self-defense) could be claimed as adequate provocation. Although the offender was not justified to using more force than necessary to repel an attack, the offender's passion in defense of self was deemed less blameworthy to warrant a charge of manslaughter. Third, feudal England social norms allowed men to defend their honor. However, mutual combat initiated by both parties in the name of preserving names and reputation did not completely justify the killing of one of the king's people. Fourth, the common law allowed a person to struggle to prevent unlawful arrest. If the struggle resulted in the death of the person effectuating the arrest, then the offense was mitigated to manslaughter.

Modern Refinements in Manslaughter Principles Law

By the mid-20th century, most states had codified the common law opting to establish criminal law statutes that are consistent with the needs of the modern era. Many states use the American Law Institute's Model Penal Code for guidance. Under the code, the law no longer allows mitigation of murder to manslaughter if the offender was engaged in mutual combat or resisted arrest. Early in the 19th century, the social conduct moral rules that previously tolerated dueling to preserve one's honor were abandoned. In the 20th century, the law pertaining to the use of force by social enforcement agents recognized the danger associated with arresting arrest. To protect both law enforcement agents and the public from the risk associated with force, the common law principle that allowed one to resist unlawful arrests was rescinded. Instead, such claims of unlawful arrest are expected to be made a court of law.

Only two reasons remain in support of the charge of manslaughter provocation rule, namely, adultery and imperfect self-defense. During the mid-20th century, heat of passion mitigation was extended to wives; nonmarried significant partners

are still not covered. The purpose of the law continues to support the principle that only married people who discover their partner committing adultery will naturally become passionately aroused. Imperfect self-defense rules allow for mitigation because, but for the conduct of the victim, the fight would not have occurred. Thus, it is recognized within the context of contemporary criminal law that the offender's anger was prompted by the victim's provocation.

Inadequate provocation exists in those situations when a reasonable person would not become inflamed. Under the common law, inadequate provocation exists when the victim engages in verbal confrontation. If a fight is provoked through of physical force, the offender can be expected use reasonable force in the attempt to repel the attacker. However, deadly force is never justified to repel verbal provocations alone. In states that follow the Model Penal Code's formulation of voluntary manslaughter, the heat of passion rule was broadened to include killings committed under extreme emotional distress. It is up to juries to determine the nature and quality of the extreme distress that would constitute a mitigated factor in a homicide.

Other Modern Manslaughter Crimes

In addition to manslaughter based on the heat of passion, newer manslaughter offenses are currently acknowledged. These offenses punish people who kill another because of their inability to differentiae between right and wrong (the mens rea concept), which is considered less blameworthy than malice. Although some states maintain the common law mental element of malice and malice aforethought, most states opt to use modern mens rea terminology as legal elements of a crime. Modern mens rea is interpreted to include the state of intent or purpose, knowledge, recklessness, and criminal negligence. Although thought by some analysts to be less ambiguous than the common law term malice, the lack of communication between mental health professionals and officers of the court continue to be in conflict.

Manslaughter offenses can also be used to punish people who kill another in unique social conditions. Under the federal law, judges sentencing offenders convicted of manslaughter can consider factors associated with domestic violence, long-term abuse of the offender by the victim, the type of weapon used and how the offender came into its possession, the length of time between the provocation and the homicide, and whether the offender suffers from a mental condition that affects his or her perception. Thus, federal sentencing guidelines differentiate manslaughter sentences based upon the degree of provocation (low, medium, or high) and if mitigating and aggravating factors exist. Offenses where the offender killed a victim who exhibited a low degree of provocation have a sentencing range of 10 years to life. Offenses with a substantial degree of provocation result in a sentence range of four to nine years.

Finally, in some states, the court is attempting to address whether manslaughter has been committed if during the course of employment a death occurs. Some state prosecutors are taking to trial companies and their corporate officers when an industrial accident claims the life of an employee and the accident is found to be the result of reckless disregard of safety standards proposed for the industry. Recent laws that enhance punishments for people distributing drugs that enhance another person's death can affect the practice of medicine for terminal patients. Health care practitioners also worry that they may be held criminally liable for the death of a terminally patient who commits suicide or for prescribing medications that are used to induce death. As recently as 2006, one state, Colorado, responded by modifying a pertinent statute to avoid punishing medical worker caregivers who prescribe high doses of pain relief for terminal patients.

Voluntary manslaughter law continues to evolve. Manslaughter remains a lesser offense than murder; but some common law principles are being modified as the focus moves from the offender's perspective to that of the victim. The law continues to mitigate murder when reasonable people respond to the stresses of life and the aggressions of another by use of force. But determining whether manslaughter should continue to be mitigated by adultery is currently being challenged in state courts. Ultimately, what is reasonable is a matter for a jury to decide. But as our sociocultural norms change, change in the parameters of the law referring to manslaughter will undoubtedly also continue to evolve.

Frances P. Bernat

See also Capital Punishment; Death, Sociological Perspectives; Dueling; Homicide; Palliative Care

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Martyrs and Martyrdom

The word martyr comes from the Greek noun *martus* meaning "witness." But the term martyr in general speech is used elastically. Often little distinction is made between someone who puts up with difficult circumstances and is therefore considered a bit of a martyr, someone of political significance who is assassinated and subsequently proclaimed a martyr, someone caught in the cross fire of a political or religious confrontation or conflict and dies a martyr, or someone who believes so strongly in something that they are willing to die a heroic, often violent death as a result of remaining steadfast in their convictions and so die rather than relinquish or concede their faith or ideals. Thus, the way martyrs and martyrdom is interpreted is fundamentally interdependent with the sociocultural, religious, and political context in which it occurs; one person's martyr is another person's traitor, suicide, or victim. The features of a successful martyr will subsequently be identified, and the nature and function of a range of martyrologies from early Jewish, Christian, and Islamic tradition will be outlined.

Through martyrdom, the martyr creates a boundary between his or her own belief system and the belief system of the oppressing and ultimately murderous other. The boundary is literalized through the action of martyrdom in a way that provides evidence of independent identity and gives increased value to the beliefs of those who support the martyr—their cause is something worth dying for. Those who may have lacked direction and focus may gain cohesion through the martyr's action. However, dying a martyr may not have an easily quantifiable or immediate effect; Christianity, for example, had to wait another 300 years after the death of Christ and the writings of Matthew, Luke, Mark, John, and Peter before the faith was truly recognized.

How to Become an Effective Martyr

For a martyr's death to achieve the maximum effect, a number of processes are necessary: the martyr must have suffered, the oppressor must be perceived as evil and unjust by the audience of the martyr's narrative, the martyr must have acted in defiance of the oppressor, and finally, the martyr must die. Preferably, spectators to the martyrdom are complicit or acquiesce in the face of the challenge posed; they might have taken action to support the oppressed but did not. These people, ideally, should feel guilty for their lack of resolve when faced with "evil." It is this guilt that can be utilized to rally people together to "right" the "wrong" experienced by the martyr and to join together against the "evil" or ruling/oppressive forces. A collective desire to expiate the failure to intervene is the reason behind a number of commemorative rituals practiced by certain faith communities: Lent for Christians or the Ashura commemoration for Shiite Muslims are examples. In addition, the event must gain publicity through an audience. This audience may not be physically present during the martyrdom, but it is essential that the event is communicated through some agent so that the important performance and narrative of death is passed on and made a part of historical memory.

This communication is just as important, or perhaps even more so, than the death itself, for

without this narrative, the impact of the martyrdom can have little or no efficacy. With a powerful and evocative narrative of events, however, the act of martyrdom can be used as a persuasive tool for consolidating belief and gaining converts. However, not every martyr's story is equally successful in inspiring conversion or in reinforcing the core aims and beliefs of a group of people. The best martyrologies have a global impact and can communicate across cultures.

Key Features of a Martyrology

To be effective, a martyrology should tell a story that the audience is able to easily identify with. It must be told at a time when there is not so much bloody sacrifice occurring that people are immune to the effect of a death. In effect, a religious or political movement will pick and choose from the range of martyrologies available in order to promote those narratives that most effectively convey their system of beliefs and that have a resonance that is likely to be a source of inspiration both at the time of the martyrdom and in the future. Furthermore, in order for death as a martyr to perpetuate the martyr's memory and cause, careful attention must be paid to the performance of the martyr's death. The martyr must die well. A "good" death is one that demonstrates exceptional self-control; in the face of the agonies to be endured, the martyr remains steadfast. When an opportunity to rescind or escape is offered, the martyr refuses. Hagiographic accounts of the process of martyrdom often linger on the gruesome details of torture and dismemberment. The martyrs in these descriptions remain unperturbed, lucid, loyal, and unmovable in their conviction. Indeed, the excruciating encounters typified in the records of their dying are often recounted as transformational experiences, the unbearable agony exceeding all boundaries of sensation and becoming a kind of impassioned, divine ecstasy.

Early Martyrs and Their Martyrologies

While Socrates is often represented as the first martyr in Hellenic tradition, having stubbornly stuck to his beliefs in spite of pressure from the state, he is also an exception to a number of the conditions previously outlined; he did not die for the sake of a cause that would outlive him, nor did his death by hemlock produce a suffering body. Instead, it is from Jewish tradition that the earliest accounts (Maccabees Books 2 and 4) of the use of martyrdom for eschatological purposes are found. These books tell the story of how certain determined individuals contributed to the liberation of the Jewish people from the tyranny of the Selucid King Antiochus IV Epiphanes (175–164 B.C.E.). One narrative that appears in Maccabees 2 and 4 tells of the martyr Eleazer, a 90-year-old man professed to be a sage, who was persecuted for upholding the sacred laws of Judaism and refusing to eat pork. This happened at a time of widespread Jewish persecution (ca. 305–70 B.C.E.). Eleazer not only died for his beliefs but also so that his steadfastness would be seen as a role model for others who might be persuaded to acquiesce in the face of torture or enticements to rescind their faith and its practices. While the process of his death is hideous (he is whipped to death), the nobility of his choice bestows dignity on his death. The other extraordinary martyrdoms recorded in Maccabees concern a mother (in the Talmud she is named Miriam bat Tanhum) and her seven sons, who were all brought before Antiochus IV for refusing to consume pork. All gladly gave their lives so that the Jewish people could be cleansed of their shortcomings. The deaths were interpreted as a means of seeking reconciliation with an enraged God who was punishing His chosen people for straying from the path He had set for them; through the suffering of this woman and her children, the Jewish people might be expiated of their sins, Israel might be protected, and faith perpetuated. Ultimately, the Selucid Empire fell some 50 years later as a result of Jewish and other anti-Hellenic resistance.

The most famous Jewish martyr, however, remains Jesus Christ. His story of sacrifice and suffering is a foundational one for the Christian faith. Since this death, Christianity has accrued a rich history of martyrs that continues to the present. Arguably the most representative of these early accounts are the martyrdom of Stephen and of Polycarp. Stephen's narrative is recounted in Acts 6:8–15 and 7:1–60 of the Bible. Stephen was a bold and determined preacher who, following Christ's death, was responsible for claiming Christ was the Messiah. He had a vision of heaven before his death by stoning at the hands of the Sanhedrin,

who was enraged by Stephen's claims. His martyrdom is significant because his firsthand experience of Christ gives his story authenticity and legitimacy. The martyrdom of Polycarp provides a historically and ideologically important narrative for different reasons.

The account of Polycarp's martyrdom forms part of early Christian writings believed to be recorded by the Apostolic Fathers—in other words, the writings of people who are thought to have had firsthand contact with Christ's apostles. The story tells of the persecution of Christians in Smyrna, with particular emphasis on the death of the Bishop Polycarp at the age of 86. It is written as a letter from the church of the Smyrnaeans to the church of Philomelium. While it praises the actions of Polycarp, it warns against the seeking out of martyrdom. The contrasting stories of Quintus and Polycarp are juxtaposed to illustrate this point.

The martyrdom of Polycarp is used as an example of the difference between an attempt at self-aggrandizement represented in the person of Quintus and that of self-effacement—represented by the figure of Polycarp. At the core of the account are the differing decisions of each man. Quintus, actively seeking martyrdom, turns himself over to the authorities and in doing so exercises his own will and judgment. By contrast, Polycarp waits patiently; always ready to sacrifice himself but never putting himself forward as a candidate for martyrdom. In other words, Polycarp exercises complete submission, whereas Quintus chooses to take matters into his own hands. It is this choice that is the key. Polycarp understands that it is only a judgment for God to make when and if he is arrested and later martyred. Whereas Quintus, seeking martyrdom and all that it entails in terms of salvation and immortality, decides to act for himself. Quintus fails as a result of his choice because without God working with and within him he is not able to withstand the torture and suffering that is his lot. Polycarp, having waited for God to act, enjoys God's grace in the face of his martyrdom and by this means is able to endure all that he is required to suffer. The narrative is there to demonstrate that God is the power at work, not individual will, and that without the power of God an individual could not possibly accept and endure the agonies allotted them in martyrdom. God's power is made manifest, not the power of the individual chosen for martyrdom. This distinction is the hallmark of Christian martyrdom and contrasts with the definitions proposed by other faith communities. For instance, after the seventh century Islamic conquest of Palestine, the Arabs translated the Greek term for witness into Arabic: *shahid*. The concept of martyrs and this word is likely to have come into use during the time of early Islam, when there were still Christian churches in Palestine and Greek was still used. The word shahid refers to men who die at the hands of non-Muslims, and more broadly to those who sacrifice their life as a result of being a witness to their faith. With this definition of a martyr, it is perfectly acceptable to seek out death in the interests of one's faith. In addition, no distinction need be made between those who die for their faith and those who die for reasons of faith and kill others in the process. In contrast to concepts linked to early Christian and Jewish martyrdom, Islamic tradition has always had fighting martyrs who engage in holy struggle or jihad.

The Prophet Muhammad took part in numerous battles and while he himself didn't seek to be a martyr, he is recorded at the Battle of Badr as encouraging warriors to do so. Indeed, Umayr b. al-Humam, a member of the Banu Salima clan, in response to the prophet's words, stated that there was nothing to stop him gaining entry to paradise except the deaths of some infidels, at which point he threw aside the dates he was eating, grabbed his sword, and headed off into battle where he died. To die "in battle" gains the deceased immediate entry into paradise. Life is not then the limit of existence, because martyrdom offers the possibility of immortality and endless pleasure, as well as a sort of revenge and triumph over enemies who are thwarted through the act of martyrdom. This understanding of martyrdom allows any fighting action carried out in the name of faith that results in death to become a story of martyrdom.

Mary E. Richards

See also Eschatology; Eschatology in Major Religious Traditions; Immortality; Jihad; Suicide

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Massacres

The word *massacre* is host to a number of different meanings but most commonly refers to individual events of deliberate and direct mass killings. The term especially takes into account noncombatant civilians or other innocents who have no reasonable means of defense. In this sense, the term massacre does not typically apply to combatants, although the deliberate killing of prisoners of war would most often qualify for this distinction.

At the same time, the term massacre is used more widely to refer to individual, civil, or military killings on a smaller scale, but having a distinct political significance of shaping subsequent events. Individual or small group murders may also be described as massacres, as would be the case in school and post office shootings. At the same time, the term massacre is often used for political or propaganda purposes, and the choice to label an event as a massacre or not may become quite sensitive.

The sheer number and volume of incidents labeled massacres makes coherent exposition somewhat daunting. To provide coherence and structure to the issue, massacres will be divided into four categories: war and terror, sociopolitical events, ethnic conflict, and anomic/criminal behavior. Understandably, any given event will often fall into more than one category, but sufficient homogeneity should exist within each category to make this approach worthwhile.

War and Terror

The early part of the 21st century has been witness to the widespread use of the concept of terror to explain repeated incidents of multiple deaths, although the concept has been around for some time and is considered by many to be a form of warfare. The incident known as 9/11, in which thousands of Americans were massacred by militant terrorists, has come to symbolize modern terrorism. Indeed, modern terrorists have come to view their activity as warfare. Throughout history, war and terror have been inextricably linked.

During the early years of American history there were numerous incidents of massacre involving the Indian population. On December 29, 1890, several hundred Sioux were camped on the banks of Wounded Knee Creek. They were intercepted by the U.S. Army and a shootout ensued. As a result, some 300 Indians and 25 soldiers were dead.

The American Civil War was also witness to numerous massacres. Probably one of the best known was the Lawrence massacre in 1863. The Lawrence massacre was the result of Quantrill's Raiders' attack on Lawrence, Kansas, which was a pro-Union town and had long supported abolition. Prior to this incident, many raiders from Lawrence had attacked and burned proslavery farms in Missouri. Quantrill's raid was in retaliation. The raid left about 200 adult and young males dead; women were spared. Many of the raiders were caught by angry mobs and lynched on the spot.

World War II was especially productive of massacres related to war. During the Japanese occupation of Nanking (1937) over 300,000 unarmed and defenseless civilians were massacred by Japanese troops. The massacre was so large that it lasted for over six weeks. In 1945, during the battle for the Philippines, retreating Japanese forces massacred over 100,000 unarmed civilians, which included many children. European history also contained massacres. In 1945, during the Battle of the Bulge, advancing German soldiers took many American prisoners. In a field near the Belgian town of Malmedy, German forces massacred almost 100 American soldiers.

Even the Olympic Games have not been spared the scourge of massacre. In 1972, at Munich, Germany, terrorists broke into the housing areas

and killed two Israeli athletes and took nine hostages. In a subsequent shootout with German security forces, all hostages and terrorists were killed. Nor have schools been spared. In early September 2004, in the Russian town of Beslan, terrorists took over 1,100 people hostage, including 777 children. Subsequent assault by Russian security forces left 334 hostages, including 186 children and the terrorists, dead.

Sociopolitical Events

The variety and magnitude of social and political conditions that can lead to massacres is virtually without limit. Such conditions can exist in the most advanced countries as well as the least developed.

Agitation for political rights has proven a fruitful spawning ground for massacres. In 1770, prior to the American Revolution, British troops were sent to Boston to maintain order. In response to torment from protestors, British troops fired into the crowd and killed five people.

On August 16, 1819, at St. Peter's Field in Manchester, England, a peaceful crowd gathered to petition Parliament to repeal the Corn Laws. Cavalry troops charged into the crowd and killed 11 people.

Massacres motivated by political conditions are found everywhere. In May 1980, in Seoul, South Korea, students were protesting a military coup. The military responded with force and over 200 people were killed. In December 2005, 14 civilians were killed by troops in Nepal as they protested government policies and had called a general strike. On August 13, 1985, government forces in Peru gunned down 69 civilians near the village of Accomarca.

In June 1989, the Chinese government used deadly force against protesting students who were unarmed. The students were protesting for more democracy in that country. At least 700 were massacred, although some estimates go much higher.

Economic conditions also are conducive to massacres. In 1897, near Hazelton, Pennsylvania, 400 mine strikers were fired at by the local sheriff and his deputies. Nineteen strikers were killed. For the first time in American history, the National Guard was called to restore order. In June 1922, near Herrin, Illinois, a mine strike led to the hiring of scabs. Over 50 scabs were killed by striking miners.

Ethnic Conflict

Ethnicity is defined as a shared cultural heritage. Ethnicity provides a fertile ground for massacres. Both large and small, massacres occur on an all-too-regular basis, and the underlying reason often appears to be ethnic differences. In the Darfur region of the Sudan, for example, there have been ongoing massacres since at least 1998 in which thousands have been killed. Arab ethnics have been migrating from the north and conducting massacres against the indigenous populations, which are mostly ethnic Masalits.

Ethnically related massacres have also taken place in Rwanda and Cambodia. In Rwanda there had been a long-term conflict between ethnic Hutus and Tutsis, but in the mid-1990s this conflict erupted into some large massacres. In 1993, about 300,000 Hutus were killed by Tutsis. The following year, Hutus killed over 500,000 Tutsis in retaliation.

After the United States withdrew from Vietnam in 1975, Pol Pot and the Khmer Rouge came to power in Cambodia. Pol Pot set about killing Cambodians who opposed his rigid policies, but eventually he turned on the minority groups as well. Ethnic Vietnamese, Chinese, and Cham Muslims were massacred. Over 50% of the Chinese ethnic group was killed. In 1979, in response, Vietnam attacked Cambodia and drove Pol Pot from power.

Early American history is replete with massacres rooted in ethnic differences, especially between whites and Indians. As early as November 1729, at Fort Rosalie in Mississippi (city of Natchez today), scores of whites were massacred by Natchez Indians. Reports at the time noted that even unborn babies were cut from the womb of pregnant women.

In Pennsylvania during July 1778, several hundred whites were massacred by Indians at the instigation of the British troops leading to the American Revolution. It was common for the British and the French to use Indians as allies against their enemies because they would completely annihilate the enemy.

During the American Civil War, hundreds of whites were massacred in the Dakota Territories by Indians in what came to be known as the Great Sioux Uprising of 1862. Over 300 Indians were tried and sentenced to death for the atrocity, but President Lincoln reduced the number executed to 38 Indians. Two chiefs who had led the uprising were kidnapped from Canada and subsequently executed.

In 1853, a federal survey team of 10 people headed by Captain Gunnison was attacked and massacred by Indians at the behest and with the support of Mormons. Gunnison had written a book critical of the Mormons to which they took exception. Subsequent trial of eight Indians for the massacre only produced light sentences (3 years each for manslaughter) much to the chagrin of the federal government, but much to the delight of the Mormon juries.

In Sri Lanka during October 1987, Indian ethnics from the Indian Army massacred almost the entire medical staff and most of the patients in a hospital. The final death toll was 68 ethnic Tamils, including 3 physicians.

During the ethnic conflict in Bosnia following the breakup of Yugoslavia, a whole series of massacres took place on both sides of the conflict. One of the worst was at Sebrenicia during 1995, in which thousands of Bosnian Muslims were killed by Serb ethnics. This event was the worst case of ethnic violence in Europe since the end of World War II.

Anomic/Criminal Behavior

Of the various types of massacres, probably the most difficult to understand are those that appear to emanate from forces beyond anyone's control, either as a consequence of crime itself, or as a result of anomie. Emile Durkheim defined as anomie the condition in which society had come to provide little or no moral guidance to individuals. Many massacres, especially in schools, seem to provide the message that moral guidance has gone awry with terrible consequences.

On April 16, 2007, a troubled student at Virginia Tech University, over a period of 2 hours, killed 32 students and faculty, wounded many others, and eventually committed suicide. That the student's problems were known to the university and police before the incident made the matter even worse and called into question the entire issue of gun control.

The Virginia Tech University incident was actually the most recent in an ever-growing list of school massacres in the United States, and copied in other countries around the world. The worst school massacre in terms of number killed was the Bath School in the state of Michigan. On May 18, 1927, three bombings at the Bath School killed 45 and injured 58. A school board member, who was angry about an increase in taxes, killed his wife and burned down his farm early that morning, then went to the school and detonated several bombs. The last bomb was a car bomb that exploded and killed him while firefighters were attempting to put out the fires that were started by previous bombings. Over a quarter ton of explosives that had not detonated were later found inside the school.

On August 1, 1966, a student at the University of Texas climbed to the top of the Administrative building with many weapons and ammunition. He subsequently killed 14 and wounded another 31 before being killed by the police. On April 20, 1999, at Columbine School near Denver, 2 students went on a rampage with guns and killed 12 students and teachers and then committed suicide.

The condition is not confined to the United States. On December 6, 1989, at the Ecole Polytechnique in Montreal, Quebec, Marc Lepine killed 14 women and wounded 10 men and 4 women. Written notes left behind (he committed suicide at the scene) claimed that he was "fighting feminism." On August 16, 1991, Wade Frankum entered the Strathfield Mall with a semiautomatic rifle and killed 6 people and then hacked a 15-year-old girl to death with a knife. He committed suicide at the scene. In February 4, 2007, two immigrants entered a Chinese restaurant in Stade, Germany, and gunned down 7 people. Some of the victims had been tortured before being killed. On September 24, 2008, Matti Saari entered a vocational school where he was a student in town of Kauhajoki, Finland, and killed 9 students. He committed suicide at the scene. The shooter had previously posted a video, but according to the police they were powerless to stop the shooter.

Finally, there are simple, criminal massacres, of which the most famous in the United States is known as the St. Valentine's Day Massacre. On

February 14, 1929, seven men were massacred in a garage in Chicago, Illinois. The murders were the result of gang warfare over turf.

A summary of these examples may not be plausible at this time. Given the variety of examples as shown in this entry, studies that strive to identify possible causes for why massacres occur are unable to provide a conclusive explanation.

Ronald E. Jones

See also Anniversary Reaction Phenomenon; Death Squads; Memorials, War; Terrorism, Domestic; Terrorism, International

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Mass Suicide

Mass suicide is defined as the death of a large group of people who wanted to die, sought to die together at a predetermined or approximate time, and acted in a voluntary and intentional manner to produce this outcome. These key features distinguish the mass suicide from other types of suicidal behaviors, such as unrelated anomic suicides during times of profound social change, or cluster suicides, caused by the Werther effect, where the lyrics of a song or a piece of literature depicting suicide allegedly promotes copycat behaviors among people who encountered the art work. The mass suicide occupies a prominent place in studies on destructive communal behavior, and is a universal, albeit rare, cultural phenomenon. Some important historical and contemporary examples of mass suicide, the causes of this group behavior, various typologies of mass suicides, and the roles of religion and charismatic leadership in specific cases are discussed.

Historical Examples

Many of the historic examples of mass suicides have one thing in common: They were often a form of political protest by a group of people singled out on the basis of race, religion, ethnicity, or some other collective identity. These groups, the members of which viewed themselves as victims of state repression or an unfair social system, employed the mass suicide as a means of escaping tyranny or to avoid capture and death at the hands of an enemy perceived as cruel or unjust. Mass suicides were a potent remonstration and Pyrrhic victory for the deceased, who were often assured of receiving a sense of symbolic immortality in the memories of future generations who would tell of their heroic, fearless, and audacious termination at their own hands.

Jauhar

In medieval India, the practice of mass self-immolation, called *Jauhar,* was a type of suicide behavior largely associated with women and children, and meant to ensure an honorable death in the face of defeat by an invading army. In Jauhar, women would build a large funeral pyre and collectively hurl themselves—and their children—into the flames. Jauhar signaled that there was no other honorable alternative for the women survivors because their fathers, husbands, and sons had been defeated in war, and that seizure by the invading army would probably mean mass humiliation as subjected prisoners, or worse, sexual debasement. Mass suicide by self-immolation was a last act of collective resistance and the only available mechanism of ensuring the honor of the group. The most frequently cited historic example of Jauhar, in the literature on mass suicide in India, is the women of the Fort of Chittor, who committed mass self-immolation after defeat by an invading army. Led by Queen Padmini, the women of Chittor decided on self-immolation after the failed, yet valiant, effort of their kinsmen to defend their sovereignty against the invading military of the Sultan of Delhi, Allah-ud-din Khilji.

Russian Old Believers

Another historic case of the mass suicide as a politically driven action was the Russian Old Believers in the late 17th and 18th centuries. The schism that led to acts of mass suicide by the Russian Old Believers began with reforms that were implemented by Nikon, the Patriarch of the

Russian Orthodox Church under the auspices of Tsar Alexis. These religious reforms were intended to realign the liturgics of Russian Orthodoxy with Greek Orthodox practices. Nikon believed that the Russian Orthodox Church had severely strayed from the strict liturgical customs preserved by their Greek counterparts, and he wanted the Russian Believers to come back to a more traditional ritual. Many Russian Believers felt that Nikon did not have authority to impose this new system of reforms, especially because the Tsar was supporting his actions, and a split ensued between those who supported the change and those who were faithful the "old" Russian liturgy, under the leadership of Archpriest Avvakum. The Russian Old Believers saw the reforms as a signal that the eschatological apocalypse was near. Mass suicide, by collective self-immolation, was the chosen instrument by which many Old Believers sought to protest against the increasingly life-threatening persecution they encountered from the State and from the now-reformed Russian Orthodox church. In fact, thousands of Believers participated in a succession of mass self-immolation between the late 1600s and the early 1700s.

Sicarii at Masada

The most notable example of historic mass suicide, and the one whose narrative occupies a prominent and compelling place in both Jewish and non-Jewish heroic traditions, is the Sicarii mass suicide at Masada during their revolt against the Romans in 73 C.E. Josephus's account of the Sicarii resistance fits the aforementioned historic pattern of the use of mass suicide as an endgame political strategy for an oppressed group. The Sicarii, a group of Jewish resisters to Roman occupation, who were led by the charismatic Elazar Ben Ya'ir, occupied the Masada compound and defended it from a three-month siege by a Roman Legion. When the Roman army eventually overtook Masada, they found that the 936 inhabitants of Masada chose to die rather than to surrender as defeated prisoners.

The aforementioned examples, the Jauhar self-immolations of medieval India, the self-immolations of the Russian Old Believers of the 17th and 18th centuries, and the Sicarii martyrdom at Masada in 73 C.E., fit the pattern of suicide as political protest, eschatological endgame, and an act of collective insurgency. These historic examples also showcase the use of suicide as a Pyrrhic liberation strategy for subjugated social groups. While some contemporary mass suicides have expressly political motives, coupled with the collective mindset of being under siege by an outside power, as in the cases of The People's Temple mass suicide of 1978 or the Branch Davidians mass suicide of 1993, most cases are nonpolitical and religious in nature.

Contemporary Examples

The 20th century has witnessed some of the most ghastly spectacles of mass suicidal behavior. The spectacle nature exists because of the role that visual mediums, namely television and the Internet, play in popularizing massive deaths. The most notable case in point is the macabre television images of 913 decedents of Jim Jones's People's Temple in Guyana, November 18, 1978.

Jim Jones and his followers initially left the United States in 1977 with the goal of building a utopian religious community in the jungles of Guyana, but eventually ended their lives by ingesting a cyanide-laced drink in an act he referred to as "Revolutionary Suicide." Jim Jones believed that the People's Temple was besieged by the federal government, who was threatened by its utopian experiment and actively sought to arrest its leaders and put an end to its activities. This "Revolutionary Suicide" might be understood as a form of political protest against the government by a deranged charismatic leader and his disillusioned followers. Indeed, many of the contemporary examples of mass suicide were under the headship of charismatic religious cult leaders who had a history of psychosis: Jim Jones (The People's Temple), Marshall Applewhite (Higher Source, a.k.a., Heaven's Gate), and David Koresh (Branch Davidians) stand out as examples.

Contemporary examples of mass suicides, such as the Jonestown massacre, also comprise the mass murder of group members and outsiders, the former involving affiliates who may have opposed the idea of collective suicide, and the latter involving people who may have been perceived as being a threat to the group's cohesion and continued existence. Some other notable examples of this

phenomenon include the Movement for the Restoration of the Ten Commandments of God in Uganda, where over 700 members died in 2000 in an apocalyptic mass suicide/murder event while anticipating the end of the world; the Order of the Solar Temple, with 74 mass suicides/murders in Canada, Switzerland, and France from 1994 to 1997; and The Branch Davidians in Waco, Texas, with 76 mass suicide/murder decedents in 1993. These examples are cases where the mass suicides of adult cult members were coupled with the murder of children who, ostensibly, were not participants in the decision-making process and did not consent to suicide.

Cause

Some mass suicides occur because members feel themselves besieged and oppressed by society, as in the Jauhar suicides of medieval India, the Sicarii mass suicide at Masada, and the Russian Old Believers. It is external oppression that forces the group to employ suicide as a political strategy. These mass suicides are often an act of war. Other mass suicides, especially those involving religious cults, are driven by eschatological visions of a coming apocalypse and are *always* headed by a disillusioned charismatic. These proselytizing leaders convince true-believing adherents that mass suicide is a means to group salvation, and Heaven's Gate, the Branch Davidians, the People's Temple, and the Movement for the Restoration of the Ten Commandments of God are exemplars of the power of charismatic authority.

Other cases involve devotees who have a strong desire to follow a leader in death, as in the *junshi* suicides of Japan. In the junshi mass suicide, a leader's death provides an occasion for the most zealous devotees, who are now overtaken by intense bereavement, to follow their master in death. Yoshitomo Takahashi, as part of his analysis of junshi in modern Japan, describes a mass suicide by self-immolation that occurred in Wakayama Prefecture in 1986 following the death of Seiji Miyamoto, the founder of the Friend of the Truth Church. Seven of Miyamoto's closest adherents, who were determined to be with their religious teacher in the afterlife, died by self-immolation a few hours after his burial. Other types of mass suicides are compulsory or obligatory suicides during times of war, such as the *shudan jiketsu* mass suicides of civilians during the American invasion of Okinawa, or those of the legendary kamikaze pilots of Japan's Imperial Military at the end of World War II, who were ordered to commit mass suicide by turning their planes into flying bombs.

Typology

The mass suicide phenomenon would likely fall under the *fatalistic* or the *altruistic* forms in Émile Durkheim's sociological typology of suicide, although it is important to note that he did not specifically attend to the mass suicide in his 1897 study. The closest Durkheim comes to a description of the *mass* phenomenon is his chapter on imitation or cluster suicides. Nevertheless, Durkheim notes that the *fatalistic* suicide is a type that is caused by excessive social regulation where individuals feel themselves oppressed by society, and he cites the suicide of slaves as exemplars. Albert Black, in his seminal study of the Jonestown tragedy, using archival tape recordings of Jim Jones's own "sermons" in Guyana, concluded that most of these suicides were fatalistic. Likewise, the mass suicide and murder of the members of the Movement for the Restoration of the Ten Commandments of God was of the fatalistic variety.

On the other extreme, the *altruistic* suicide results from too much social integration, where the individual takes his or her life out of a deep sense of commitment or duty to the group. Lakshmi Vijayakumar, in his research on mass suicides in Medieval India, classifies Jauhar under this type. Similarly, Durkheim cites the sati of India, where widows end their lives through self-immolation upon their husbands' death, as the altruistic kind. Other altruistic mass suicides include the Junshi and Shudan Jiketsu suicides of Japan, especially the latter as seen in the kamikaze pilots of WWII.

Lee Garth Vigilant

See also Altruistic Suicide; Apocalypse; Cult Deaths; Kamikaze Pilots; Suicide, Cross-Cultural Perspectives

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Medical Examiner

In the United States alone there are over 3,100 counties that have more than 2,300 separate death investigation systems. The term medical examiner may refer to: a member of the state medical licensing body (the Board of Medical Examiners), a life insurance medical physical inspector (who may or may not be a physician), a physician in general, a coroner or similar death investigator (usually not a physician), or a forensic pathologist. For the purposes of this discussion, the term medical examiner is used to refer to the governmental physician employee specifically charged with the medicolegal investigation of deaths occurring in the jurisdiction.

The Evolution of a System of Medical Investigation

The societal interest in death investigation is longstanding. In fact, the function of medicolegal death investigator is the oldest judicial office in existence in Anglo-American law. More specifically the office of coroner (a corruption of the original "crowner") or *custos placitorum coronas,* the keeper of the pleas of the crown, is first documented in 1194 in the Articles of Eyre. However, the office dates even further to pre-Norman England circa 900. In Ancient China (ca. 475–221 B.C.E.), the government had an office charged with the function of medicolegal death investigation.

Although the original motivations for the creation of a death investigatory body are unknown, the reasons for this interest are many and have evolved with the passage of time. Originally, the function was primarily financial in attempting to maximize death-related revenues to the crown. Over time, the government's monetary interest faded as the information took on greater significance. The office of coroner immigrated to the colonies and continued much as it had in the United Kingdom. Gradually the medical aspect became more important and physicians became involved in the process, eventually giving rise to the medical specialty of forensic pathology and the office of the medical examiner.

Initiatives undertaken within the Northeastern United States were responsible for this gradual advance of the science of death investigation. Maryland was at the early forefront of professionalizing death investigation with the coroner permitted to require physician attendance at inquests as early as 1860. This was followed by an elected physician coroner position created in 1868 and physician medical examiners performing autopsies for the coroner in 1890. Massachusetts replaced coroners with physician medical examiners in 1877. The first medical examiner system, in the purest sense, began in New York City in 1918.

Over time, the need for increased professionalism became more apparent and the modern concept of medical examiner spread. Roughly every 15 to 20 years since 1928, the need for improved medicolegal death investigation is recognized at a national level. One of the most significant such analyses resulted in the creation of a Model Postmortem Examinations Act in 1954 by the Uniform Law Commission. The result was establishment of a plan for improved death investigation by a local implementation in interested communities of a functional plan. There ensued a flurry of activity and creation of many new medical examiner systems across the country up to about 1990,

at which time the movement toward improvement stalled at both the state and local levels.

At present, approximately one-half of the U.S. population (one-third of all counties) is served by a medical examiner system: 22 states have pure medical examiner systems without coroners, 14 states have mixed medical examiner/coroner systems, and 14 states have nonmedical examiner systems. Organizational oversight of the medical examiner death investigation office varies widely: 10% forensic laboratory, 14% health department, 33% public safety/law enforcement, and 43% other governmental office. The management niche occupied by the office of the medical examiner may seem trivial, but in fact it may be a major determinant of the focus of the office in how cases are accepted and which cases get major scrutiny as well as how funding is allocated.

Forensic Pathology

The forensic pathology specialty that embodies the ideals of professionalized medicolegal death investigation conducted by medical examiner is fairly new, having been recognized by the American Board of Medical Specialties in 1959. But the specialty is quite small; of the total 15,000 medical students in America, only 3% (500) continue their postgraduate medical training in the general field of pathology.

There are presently 39 accredited training programs in forensic pathology in the United States that put out fewer than 50 trained forensic pathologists each year. Since 1959, a total of 1,300 physicians have attained board certification in the discipline, and of those, only 400 are active full time. To illustrate the need for additional practitioners, that equates to 375 to 1,000 autopsies per medical examiner. National performance standards recommend no more than 250 autopsies be performed per forensic pathologist. Laboratory accreditation is not permitted for pathologists performing in excess of 325 to 350 autopsies each year.

Forensic Autopsy

The major tool employed by the medical examiner is the forensic autopsy. This differs from the conventional hospital/medical autopsy conducted by a general anatomic or hospital pathologist in significant ways. Generally, the medical examiner is empowered by law to conduct an examination, the extent of which is determined by the medical judgment of the forensic pathologist, in order to determine the cause and manner of death. The general pathologist, on the other hand, receives permission from the decedent's legal next of kin to conduct an examination, the scope of which may be limited by the requestor to as little as one organ, which may not even be allowed to be removed from the body. The medical examiner is involved in determining how and why an unnatural death occurred, while the hospital pathologist is generally involved in elucidating the mechanisms involved in natural deaths in order to address clinician questions relating to disease.

In addition to the visual examination of the tissues of the body at the macroscopic (gross pathology) and/or cellular level (histopathology), the forensic autopsy may employ numerous specialized procedures, most often including toxicology testing, specialized chemistry, metabolic disease testing, and microbiology cultures. Not all examinations require every test, and clinical judgment includes or excludes certain tests. The prudent practitioner considers not only the physical examination, but also the case history of past medical events and perimortem circumstances, as well as clinical data derived from review of the patient's medical record and clinical course immediately prior to death.

All of the case information is ideally considered prospectively and retrospectively as superimposed on the context of the scene of death. All death investigations begin at the scene and a great many shortcomings may be traced to inadequate scene documentation and/or procedures. Such basic questions as estimated time of death are best addressed by a knowledgeable examiner conducting a physical assessment of the body as found at the scene as soon as possible—the passage of time broadens the window of the estimate and allows less precision.

Issues Related to Duties of the Office

Regardless of the overall governmental niche occupied, the medical examiner must be functionally independent of other agencies and processes such that the medicolegal conclusions reached may not

be influenced or reasonably perceived to have been influenced by individuals with an agenda that is contrary to the impartial, scientific determination of the circumstances surrounding a death. In addition to system limits, significant differences exist between practitioners. In the end, the final determination of the cause and manner of death by a medical examiner are professional opinions, based on available information as filtered through the lens of years of training and experience, and may be held to different levels of certainty, either reasonable probability or reasonable certainty. One might criticize an autopsy for acts of commission but more frequently cited are omissions during the course of the original exam. A recent trend has been lawsuits attempting to limit the medical examiner's authority to retain tissues/organs deemed necessary for an appropriate diagnosis, which is the whole purpose of the autopsy. Equally troubling have been legal efforts to remove an established cause and/or manner of death, over the objections of the medical examiner, because someone was not pleased with the answer(s) provided.

System Commonalities

Although the systems vary by jurisdiction, there are some commonalities. All death investigations are controlled at the state level; however, the extent of this control varies. A properly functioning system deals with numerous societal concerns, including multiple and often overlapping roles—medical, public health, and justice—within the criminal and civil courts. At the core, the system is driven by the cases investigated, which is fairly uniform. The broadest definition includes cases involving sudden, unnatural, unexpected, or unexplained death and/or injury and those without a physician in attendance.

Additional specifics mandated by some jurisdictions include deaths associated with known or suspected poisoning, unusual or suspicious circumstances, environmental conditions, workplace events, police custody or involving law enforcement, public health concerns, and medical procedures/anesthesia use. A recent trend has been that deaths of juveniles, especially the very young, have special, legally mandated scrutiny. The ideal would be that all death cases would be adequately investigated with a minority of fatalities requiring further scrutiny by a medical examiner. In practice, this is often not the case. The cases that are too often overlooked are those deemed obvious by the inexperienced. Regrettably, these cases include elder and infant deaths where abusive trauma may have been involved. Another area neglected are homicides masquerading as apparent suicides or even natural deaths, written off based on inadequate investigation and lack of suspicion by those responsible for determining the true nature of the case.

Simply because a death falls under the legal requirement for medical examiner jurisdiction does not necessarily mandate the extent of such examination. The medical examiner will make such decisions based on many factors, including available resources, legal requirements, best practices, and local custom. For example, in some areas, religious objections to an examination may supersede the medical examiner's authority to take jurisdiction of the case and/or set limits for the procedure. Thus, specific religious proscriptions may operate to prevent an autopsy from being conducted. Likewise, an individual office may decide that all witnessed gunshot wound suicides are not worthy of more thorough analysis. In some areas, not even all homicide deaths require autopsy examination—in short, for myriad reasons, there are no national standard operating procedures in place.

Standards of Practice and Law

Despite establishment of national practice standards by professional medicolegal death investigation practitioners in 2003, less than 60 death investigation offices in the United States are accredited by the National Association of Medical Examiners. This demonstrates a lack of sufficient minimum resources, personnel, and procedures to attain such recognition. One of the major shortcomings has to do with insufficient personnel to handle the jurisdiction's investigative caseload.

Death Investigation

Death investigation cases fall into one of two broad groups—natural (seemingly self-evident) and unnatural (accident, suicide, homicide, and undetermined). In the United States, over 150,000 deaths are certified as unnatural each year. This number may not be accurate due to variability inherent in

the investigative system. A more accurate estimate for the need of proper death investigation may be derived form the statistic that ~1% of large populations can be expected to die each year; of all deaths, ~10% to 20% (highly variable) require professional investigation with roughly half to two thirds requiring autopsy examination. Therefore, based on a total 300,000,000 U.S. population, there will be 3,000,000 deaths per annum. Of these cases 300,000 to 600,000 should be investigated and of those, 150,000 to 400,000 autopsied.

J. C. Upshaw Downs

See also Body Farms; Causes of Death, Contemporary; Causes of Death, Historical Perspectives; Coroner

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Medicalization of Death and Dying

Medicalization of the dying is a form of medical treatment that concentrates on reducing the patient's pain and suffering. It does not delay or speed up the progression of death. However, high-quality, end-of-life care is limited, and most of the extant literature focuses on patients with cancer, thereby limiting the prospects for addressing the many important aspects of end-of-life care. This is noted in that hospice organizations serve most Americans dying of cancer and only 10% of all others.

History

Medicalization of the dying patient is a part of palliative care or hospice care. The concept of hospice is both a philosophy and a specialization that has important historical characteristics that are traceable to the Middle Ages, when in its embryonic form, life-rendering assistance was provided to those who engaged in the pilgrimage to the Holy Land. In the latter portion of the 19th century, a religious order of nuns established a hospice hospital for the dying in Dublin, Ireland, and then later in London, England.

The modern hospice movement originated in the United Kingdom after the founding of St. Christopher's Hospice in 1967 by Dame Ciceley Saunders. Training as a nurse and social worker sensitized Dame Saunders to what she observed and referred to as the patients' total suffering. The intensity of her observations of dying patients and the desire to assist them prompted her to pursue studies that ultimately led to a medical degree, after which she aggressively worked on behalf of pain-suffering patients on the verge of dying.

Hospice care in the United States, which began as volunteer-led movement, has evolved into a significant part of the health care system. From the initial hospital-based palliative care programs that began in the late 1980s, more than 1.2 million individuals and their families received hospice care during 2005. Much hospice care is delivered at the patients' home, but hospice care is also available in home-like hospice residences, nursing homes, assisted living facilities, veterans' facilities, hospitals, as well as prisons.

Symptoms

Patients with serious illness at the end of life should be regularly evaluated by clinicians for pain, breathlessness, anxiety, and depression. Each one of these

symptoms can be treated with separate medications, as per palliative care protocols. Following is a short overview of the medications used to treat intractable breathlessness, anxiety, and fear.

Pain

Patients at the end of life are generally receiving treatments effective in managing pain. For patients with cancer, such therapies include nonsteroidal anti-inflammatory drugs, opioids, and bisphosphonates. The available evidence is that the prevalence of pain is high in more than 50% in all cancer types, with the highest prevalence in head and neck cancer patients at 70%. More than one-third of the patients with pain grade their pain as moderate or severe. The World Health Organization (WHO) introduced a pain scale in 1986 that has been widely accepted. Combined with information pertaining to appropriate dosage guidelines, the scale offers sufficient evidence for clinicians to adequately access and implement adequate pain relief in 70% to 90% of all cancer patients. Yet, despite these clear WHO guidelines, the pain problem has yet to be resolved. More recent studies on the prevalence of pain in patients with cancer are still high, ranging from 24% to 60% in patients on active anticancer treatment to 62% to 86% in patients with advanced cancer.

Breathlessness

Patients with serious illness at the end of life should be treated to effectively manage breathlessness. These therapies include opioids in patients with unrelieved breathlessness, as well as oxygen for short-term relief of hypoxemia. Although beta-agonists may be useful to treat breathlessness associated with chronic obstructive pulmonary disease, this indication has not been studied for end-of-life care.

Breathlessness is often the most difficult to treat. Intractable breathlessness is one of the most common symptoms of end-stage cancer. The severity of breathlessness in patients with cancer increases greatly as death approaches. Palliative care was found to only be partially successful in alleviating it. Patients have suffered from breathlessness with minimal medical or nursing assistance. As much as palliative care can treat pain, there have not been the same therapeutic advances for the treatment of breathlessness.

Many studies show that breathlessness in advanced cancer depends on many different factors, most of which are irreversible. However, it was shown by the studies that a relatively small improvement in a number of different parameters (for example, treatment of pleural effusion or anemia, coupled with reduction in the patient's anxiety and support for the caregiver) may give relief. Research has also shown that it might be most effective to introduce anxiety-reduction training for patients early in the course of managing cancer and breathlessness as the disease advances.

Treatments of Choice

Data show that oral and nebulized opioids are effective in treating breathlessness, but to date this evidence is derived from noncancer cases. According to the latest guidelines, opioids are key to breathlessness control.

Literature suggests that both oxygen and air can alleviate breathlessness in patients with cancer. The relief was seen not as much as a result of the correction of low oxygen in blood, but rather as a result of the flow of gas. Patients with insufficient oxygen in their blood may not be breathless. And even if patients are both low on oxygen and breathless, correcting the oxygen level in patient's blood does not necessarily make their breathing easier.

Helium is less dense than air. When mixed with oxygen, it replaces nitrogen in air and reduces turbulent flow in narrowed airways. Thus, it reduces the work of breathing and improves ventilation inside the smallest lung passages—the alveoli. There is one study of the effect of heliox versus oxygen-enriched air in 12 patients with lung cancer and breathlessness on exertion. Heliox 28 (72% helium and 28% oxygen) reduced breathlessness on exertion and increased both exercise capacity and oxygen saturation, both at rest and during exertion.

A number of trials of inhaled furosemide have indicated that it may relieve breathlessness in terminal cancer patients. Furosemide is a commonly prescribed loop diuretic. When inhaled as a mist, furosemide has various actions on lung tissues that inhibit cough and protect against bronchoconstrictor stimuli. However, these actions do not fully explain breathlessness relief in the absence of asthma or other lung diseases.

Phenothiazines are preferred when sedation or anxiolysis is needed in severe breathlessness. A low dose can be added for patients still experiencing intrusive anxiety.

The use of benzodiazepines in the treatment of breathlessness is less supported in the literature than that of phenothiazines. Phenothiazines may be the drug of choice when the patient's fear is out of control at the end of life. If fear, instead of anxiety, is the primary concern of the dying patient, the addition or substitution of levomepromazine or haloperidol is frequently recommended.

Depression

End-of-life depression treatment studies primarily focus on cancer patients. Tricyclic antidepressants and selective serotonin reuptake inhibitors are uniformly effective, given sufficient treatment duration. Studies also report that education, cognitive and noncognitive behavioral therapy, informational interventions, and individual and group support are beneficial. Although palliative care does not seem to improve depression per se, such care does seem to improve the patients' spiritual well-being.

One Treatment for All

The preferred form of medicalization in dying patients is continuous, deep sedation with benzodiazepines, used to control all of the patient's symptoms. In this case, breathlessness, pain, anxiety, and fear are all taken care of by the continuous administration of one medication. Authors point out that palliative care is personalized and costly, while continuous sedation is a relatively inexpensive, one-size-fits-all treatment. Also considering that most of the hospice care is still administered by general medicine doctors, and not by palliative care certified specialists, continuous sedation represents a simple method of addressing the different aspects of patient's suffering. Sedation is increasingly considered as part of regular medical practice among United States and United Kingdom physicians treating terminally ill patients who are close to death. However, with this uniform treatment, sedation may be used as a substitute for meticulous assessment and intensive treatment of physical symptoms and psychological or spiritual distress.

Regina Belkin

See also Death, Clinical Perspectives; Halo Nurses Program; Hospice, Contemporary; Hospice, History of; Palliative Care

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Medical Malpractice

Death is a normal and inevitable part of the human experience. Under the physician's hand, death is a regular occurrence, as these practitioners strive to ward it off for us, for example, in critical care surgery. It is physicians who certify death, and their close relationship to this final stage of the human experience contributes to their status. However, death *by* a physician's hand, due to negligence, strikes at the heart of the Hippocratic oath: "first, do no harm." An instance in which a physician causes injury or death to a patient through negligent behavior is called medical malpractice. Negligence is action that fails to follow acceptable standards of practice. Estimates of deaths resulting from negligence are unreliable, ranging from the low thousands to the high hundreds of thousands per year, depending on who is counting and how broadly negligence is defined. Malpractice is consequential not only for the welfare of patients, but also for the professional status of physicians and the trust the public bestows upon them. Medical injuries, medical errors, negligence, and malpractice claims are complex phenomena, involving the legal tort system, the economics of health and liability insurance industries, the risk-management industry, consumerism, the patient-doctor relationship, the status of health professions, political stakeholders, the welfare of the population, and the ambiguities of death and dying.

Distinguishing Negligent From Normal Injury and Death

Medical malpractice claims arise from adverse health *outcomes* that occur under the care of a physician. If a physician is negligent but causes no injury, then there will likely be no claim. It is the effects of injury, including psychological injury to survivors of a wrongful death, that serves as the basis for monetary settlements. When an injury occurs, a malpractice claim is an assertion that it was caused by misdiagnoses, poor mastery of treatment standards, or observable practitioner error. However, medical complexity and uncertainty make establishing negligence difficult. Deaths and injury (e.g., the surgeon's cut) are a normal part of medical practice and life. Less than 20% of malpractice claims are *res ipsa loquitur* cases, those that "speak for themselves," such as mistaken amputation of a healthy limb. In the remaining cases, it is difficult to discern a normal adverse event from preventable medical error. This ambiguity leaves the process of determining what really caused an adverse outcome to variable interpretations. As a result, stakeholders other than doctors have a say in constructing and interpreting the facts within the context of an adversarial civil law (or tort) system. Especially for an untimely death (e.g., an infant), aggrieved survivors may seek justice for economic and psychological costs. Medical uncertainty means that negligence is continuously redefined in the evolution of tort law as well as in the medical arena itself.

Medical uncertainty is reflected in summary statistics on the incidence of avoidable medical injuries, adverse outcomes, medical errors, and malpractice claims. Data on malpractice claims (legal facts) and medical error (a frequently ambiguous assessment) are skewed by assorted stakeholders, including claimants, defendants, physicians, hospitals, trial lawyers, medical liability insurance companies, and patient advocacy groups, all of whom use different operational definitions of injury and negligence. Physician estimates focus on *res ipsa loquitur* cases and exclude systemic errors, such as poor infection control in hospitals. Their estimates of malpractice-caused deaths per year are in the low thousands (e.g., 6,000–12,000). Estimates by legal interests define practitioner-caused mortality broadly and include systemic errors. Their estimates are as high as 780,000, about one-third of all deaths, making medical errors and negligence a top-three cause of death. Even objective researchers must make assumptions that favor one or another stakeholder. Statistical analysis of malpractice is complicated further by varied litigation processes; distinguishing injuries and adverse outcomes, claims, and lawsuits; active and disposed cases; out-of-court settlements and jury verdicts; and jury and actual monetary awards. These legal processes vary somewhat by state and court jurisdiction.

Regardless of a claim's resolution, real negligence may or may not have occurred. Nonetheless, claims data are posed as indicators of the occurrence of malpractice.

While an objective assessment of medical negligence is hampered by the complexities of medicine and the politics of stakeholders, the uncertainty of medical practice assures that many injuries and deaths occur from undetected negligence and go unclaimed. And timely deaths, such as with elderly people, often are not scrutinized.

The Legal Context of Malpractice Claims

Notwithstanding the complexities of identifying true negligence, enough physicians have incurred claims that it is no longer a surprising event, especially for obstetricians and surgeons. Over half of all physicians have incurred a claim at some time in their careers. Many State Boards of Medical Examiners and consumer groups post claims histories on the Internet.

While negligent physicians most assuredly have always existed, an increase in malpractice claims is a relatively recent phenomenon, reaching public knowledge in the early 1970s. Historical changes in medicine, law, and society are posited to explain what amounted to an abrupt increase in claims and settlement costs. This surge of cases followed changes in tort law allowing patient-claimant attorneys to use expert witnesses from outside the local community. Physician defendants then had to show adherence to national rather than local standards and answer to other than their colleagues in the local medical society. An increase in just a few high-dollar claims created a financial "malpractice crisis" by the mid-1970s, characterized by inflation of medical liability insurance premiums. In some states, such as California, Maryland, New York, Ohio, and Texas, medical liability premiums jumped fivefold in one year. Since that time, periodic financial crises have occurred with cyclical downturns in the stock market. When liability insurance company stocks drop in earning value, it requires adjustments in liability insurance premiums to cover anticipated malpractice losses. Whether increases in malpractice cases are due to more negligence or to changes in tort law is unclear; however, the rapid increase of all types of litigation in the United States suggests the reason is change in tort law.

The Financial Impact of Malpractice Litigation

From an economic standpoint, some medical inflation results from malpractice settlements and premium costs. Mere physician fear of litigation incurs costs, as physicians seek to avoid claims. Risk-reduction is now a standard practice, and defensive medicine—physicians ordering extra tests, second opinions, and referrals to high cost specialists for fear that records may be scrutinized in court—has become institutionalized. What was once called defensive medicine is now seen as *more thorough care*. At least for patients with comprehensive access, this care has resulted in some cost inflation, although the extent of it is debated among stakeholders. In state governments, where health legislation resides, business interests, such as professional physician groups, hospitals, medical liability insurance firms, health insurance companies, and the corporations that pay employee premiums, typically spar with trail lawyers and consumer rights groups. Business interests partly blame malpractice litigation for recent health care cost inflation, reductions in health care access, and a growing uninsured population. Some states have capped jury awards for pain and suffering, but the effect of this legislation on overall costs is disputable.

The Impact on the Quality of Care

Notwithstanding the fact that much defensive medicine is medically unnecessary, from a patient-welfare perspective, a case may be made that, for those with access to health care, the quality of care is enhanced by the implicit accountability inherent in malpractice tort law. Strathern's concept of audit culture explains some of the increase in litigation. An audit culture is part of the corporatization of all aspects of the economy including health care. In an evolving audit culture, organizations and individuals are increasingly being held to account and subjected to economic as well as behavioral audits, such as performance evaluations. Job performance is assessed with scorecards that require setting benchmarks. The idea of an audit carries with it assumptions that job tasks have rational certainty with clear causal paths from actions to outcomes and that actions can be accurately measured. Such rational assumptions run head-on into the inevitability of death, and the uncertainty of

medical tasks and the practitioner autonomy they require. Physicians plead for trust in professional judgment, while auditors, such as hospital review boards, health maintenance organizations, and tort lawyers, want a full accounting. From the physician's standpoint, these are extraneous forces, but they are legally and morally powerful. To argue against an audit is to stand for soft standards and privilege. Resistance to audits implies that there is something to hide, and that a practitioner is not only incompetent but also dishonest. Furthermore, the philosophical context of audit culture carries with it moral undertones that demand punitive resolutions for less than stellar audits. When a physician not only fails to meet a goal but also causes avoidable harm or death to a patient, this constitutes an unfair economic transaction *and* a moral breach of trust. Moreover, consistent with the accounting practice of focusing on the bottom line, audits tend to center on *outcomes* rather than process. As a result, even an untoward treatment outcome unrelated to physician behavior, such as an unavoidable childbirth death, may nonetheless incur a charge of negligence. From a family's perspective, it is not supposed to happen. In an accountability-oriented society, medical uncertainty must coexist with the highly valued ideal of calculated, auditable certainty and moral certitude.

Sociological Perspectives on the Malpractice Crisis

A sociological way to conceive of the malpractice trend of the past four decades is from the perspective of medical rationalization. This approach combines the processes of audit culture and corporatization with larger change processes, such as the medicalization and biomedicalization of society and rapid medical innovation and its implications for patient-physician interaction and trust. The most obvious aspect of rationalization is an increase in formality, stricter standards and rules that guide a practitioner's actions. This is a focus not so much on the outcome of work, but the structure and process of working. For physicians, it involves a transition from a highly autonomous practice style to one that has traces of production line work. For example, mandated risk-management procedures in hospitals force physicians to follow risk-assessed protocols, to accept peer review, and to relinquish certain tasks to other physician specialists and health practitioners. Rationalization is systemic. For example, liability insurance carriers set premium charges according to medical specialty and require specialty certification. As a result, clearer delineations of task boundaries among physician specialists occurred rather rapidly after the initial malpractice crisis in the mid-1970s. The medical malpractice crisis is an instance of two institutions, medicine and law, becoming intermingled. The highly rational structure of law is superimposed on the highly uncertain institution of medicine. While many outcomes of this phenomenon may be positive, such as an increase in accountability and medical care quality, many unintended irrationalities are likely to occur. Fear of litigation influences patient–practitioner interaction in both positive and negative ways. The medical malpractice crisis is part of a larger patient's rights movement, which many health ethicists view as a positive phenomenon that enhances the quality of care. On the other hand, physician fear of malpractice litigation encourages stereotypes of *suit-prone* patients, who may be treated differentially.

Malpractice issues also inform theories of medical deprofessionalization and countervailing powers, concepts that challenge notions of professional medical dominance. Finally, there is literature on differences in how stakeholders view the issue, especially physicians and lawyers.

Ferris J. Ritchey

See also Death, Sociological Perspectives; Informed Consent; Legalities of Death; Medical Mistakes; Wrongful Death

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Medical Mistakes

Medical mistakes, or medical errors as they are called in research literature, are terms that defy easy definitions. In a widely cited report on adverse medical outcomes titled *To Err Is Human: Building a Safer Health System*, Kohn, Corrigan, and Donaldson of the Institute of Medicine (IOM) define medical error as the failure to achieve an intended goal either because of a failed initiative or a plan of action that is ill conceived.

This means that errors can occur in execution, in planning, and at all stages of practitioner–patient interaction. There is a wide range of medical errors, including failure to diagnose, misdiagnosis, and late diagnosis; drug prescription and administration errors, and failure to foresee adverse reactions among multiple prescriptions; over-, under-, and misprescribing of medications; surgical and procedural errors; overuse of diagnostic tests and surgical procedures, such as Caesarian sections; mistakes in choice of intravenous (IV) solutions, their concentrations, and drip rates; mishandling of medical records and test results; and failure of aseptic procedures resulting in spread of infections in hospitals. However, it is important to be mindful that injuries, such as surgical cuts and adverse outcomes, such as medication side effects, are expected to have a certain occurrence. In risk assessments, as long as a treatment does more good than harm, a rate of occurrence of side effects is deemed acceptable. However, if an unusual injury or adverse outcome occurs where a risk assessment is unclear, regardless of whether it was preventable or due to practitioner negligence, the event may appear as error. Thus, studies of medical errors often define them as adverse events that could have been prevented.

The complexities of the previous definitions reveal that identifying medical error is itself fraught with potential error. With injury being a normal part of surgery, and treatment often incurring side effects, distinguishing normality from error is difficult. The IOM report describes in detail the multidimensional nature of errors and the challenges of identifying and preventing them. In fact, the IOM report's main impetus is a call to apply to medical settings the standard safety and risk management practices found in other industries that place people at risk, such as the airline industry. The emphasis is on safety and the prevention of adverse events through systemic changes in organizational procedures and professional culture. If an adverse event can be avoided, whether or not the treatment process included errors is a moot issue.

However, the practice of medicine is distinct from other industries. Medical care is about trying to save people as well as keeping them safe. For example, in hospital care even the extreme outcome of death is normal. In contrast, in most other industries, even those that are risky such as airlines and mining, there is no justification for a death. Error and risk assessments in medical care delivery occur in the context of biomedical complexity, esoteric knowledge, and the resulting uncertainty of medical practice. Notwithstanding periodic fluctuations in occupational prestige, medical practice has professional components that make it distinct from industrial work. Medical practitioners are allowed a degree of professional autonomy that overrules and sometimes conflicts with the formal rationality of typical production bureaucracies. This means that what constitutes error depends on what constitutes standard procedures, but many such procedures are necessarily elastic. Medical practice standards are normative. They depend, at a particular time in history, on a society's level of medical and organizational knowledge, its resources, and its epidemiology, including socially produced mortality and morbidity.

Furthermore, patients bring assorted risks with them. Patient ailments and the procedures applied to remedy them carry variable levels of risk for adverse outcomes. Each patient's condition varies according to presenting symptoms, which depend on age, health, functional capacity, propensity to certain illnesses, severity of condition, comorbidity, and the ability to clearly communicate. Moreover, treatment regimens, patient adherence, and biological and psychosocial reactions to treatment depend on a similar assortment of personal variables.

Herein the term *medical actions* refers to all aspects of diagnosis and treatment, including decisions, clerical actions, analysis of test results, prescription of treatment, manual treatments such as surgery, and communication with patients and other practitioners. From the practitioner side, there are individual, systemic (i.e., part of organizational structure), and circumstantial variables

that influence medical actions and the likelihood of a patient incurring an adverse outcome. Individual factors include (a) overall practitioner competency (e.g., training, certification, expertise, years of experience), which can cause mistakes in the choice of medical action; and (b) typical human error, what Reason (1990) calls a slip or lapse, a correct choice of action but poor execution due to the "human element." Systemic factors are those related to the standard formal operating procedures of a medical organization as well as its organizational culture, which includes informal norms and procedures tied to professional authority. These factors include (a) the medical protocols of a hospital; (b) quality control and risk aversion procedures, such as procedural checklists and mortality and morbidity review committees; (c) type and efficiency of health information and prescribing systems (e.g., reliance on paper or electronic records); (d) efficient and safe division of labor, for example, appropriate integration and use of assisting practitioners, such as clinical pharmacists; and (e) quality of working relationships among practitioners and other staff. Circumstantial factors that can increase risk of medical error include (a) distractions and strains in work settings (e.g., a rush on a hospital emergency room due to a tragic event) and (b) personnel staffing issues, such as a shortage of nurses or other practitioners, serving too many patients, covering too many places at once, or working long hours.

The multidimensional features of medical error are apparent in a number of ways. First, it is critical to determine whether medical error did in fact occur. Second, it is important to determine whether corrective actions were taken. A third issue pertains to whether an error was detected. Many errors occur but go unnoticed. Fourth, if an error was detected, it may or may not have been brought to anyone's attention or reported to the patient or organizational authorities. An alleged error in treatment is unlikely to be acknowledged and reported unless it was consequential for the patient's prognosis and revealed in an adverse outcome. A fifth issue is whether an adverse outcome could have been avoided. Many adverse outcomes occur despite the remedies applied and despite whether those remedies follow standard practices. For example, a 90-year-old man dying of cardiac failure during hip surgery is a calculable risk, and this adverse event happens when standard or even state-of-the art procedures are followed. Irrespective of whether an error occurs in these types of situations, it might be attributed to known risk and spelled out ahead of time in informed consent papers. The multidimensional nature of medical error means that assessments of it are seldom straightforward. Even for alleged medical errors that evoke malpractice suits, only about one in six are indisputably determined to result from practitioner negligence. The questions of error and negligence usually evolve around the occurrence of an adverse outcome and whether it could have been prevented. But medical "preventability" is stochastic; that is, risks occur with a probability. These perplexities reveal the difficulties of identifying and analyzing medical errors, and this is reflected in the large range of statistical estimation error for reported incidences.

The Incidence of Medical Error

The IOM report gained widespread coverage because of its notable statistics on the incidence of preventable deaths attributed to medical errors. Estimates were based on a thorough analysis of two hospitals. After extrapolating the data to all U.S. hospitals, the authors concluded that between 44,000 and 98,000 Americans die each year because of medical errors, representing about 3% of all hospital admissions. These estimates shocked the public, especially since many medical errors go unreported. In the aftermath of the IOM report, research on medical error greatly increased. Much research attempted to refine estimates with some disputing the high estimates of the IOM report. Others affirmed the IOM estimates or even suggested that these estimates were low. However, medical error was operationalized in assorted ways and many studies tended to focus on one type of adverse event, such as hospital infections.

Two things are clear from the research on medical error. First, it is impossible to establish a consensus on what constitutes medical error, how it is to be operationalized, and the reliability of extrapolated estimates. Second, notwithstanding measurement challenges, preventable medical error occurs at unacceptable rates and more research is warranted on how to reduce it. The IOM report and subsequent research is refocusing the

discussion to the issue of patient safety, with the intent of not only preventing medical error, but also enhancing care quality.

Making the Health Care System Safer

As the IOM report notes, error is prevented when the health care process is made safer. The IOM report, the Agency for Healthcare Research and Quality (AHRQ), and a multitude of researchers propose the following systemic changes: infection control measures, electronic record keeping and computer entry of physician orders to reduce prescription errors and enhance communication among practitioners, health team training and use of protocol checklists, workshops and knowledge dissemination on established best practices, and increased grant funding for patient safety research.

The IOM report criticizes punitive approaches that seek to prevent medical error by scrutinizing individual human error. Instead, it emphasizes that error prevention requires correction of the systems and contexts in which medical work occurs. But despite calls for systemic changes in the report, recent researchers continue to lament the strong tendency for punitive, individualistic remedies. Public and political interests are slow to view patient safety as a complex systemic problem requiring scientific analysis. It is too easy to view system failures as simply bad doctoring, and this narrow perspective leads to a simple solution: Remove the bad doctors and the problem will be solved. There is even outright resistance to an emphasis on systems. Not blaming individuals for errors is viewed as subterfuge, an attempt by powerful doctors and hospitals to hide the problem. As a result, legislation typically calls for stricter reporting requirements for physicians and hospitals to expose wrongdoers and hold them accountable. Fixing blame takes precedence over improving patient safety through preventive measures. This preoccupation with individual responsibility and personal accountability guides legislation on this issue as it does on most social legislation in the United States.

Advocates for systemic change do not disregard personal accountability. Full disclosure of medical errors to patients, hospitals, and third parties is a persistent issue. Research continues on systemic changes in patient safety, but advocates of the issue seek greater grant funding. Systemic change requires more than a change in the professional and shop floor cultures of medical settings. It requires cooperation among multiple federal agencies, professional associations, state and federal governments, hospital associations, and patient-advocacy groups. Medical error is a sociopolitical as well as biomedical issue.

Ferris J. Ritchey

See also Appropriate Death; Death, Clinical Perspectives; Death, Sociological Perspectives; Medical Malpractice; Wrongful Death

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Megadeath and Nuclear Annihilation

Nuclear and thermonuclear weapons, two terms that are used interchangeably, constitute a preventable cause of mass megadeaths. Actual mortality

data (number and rates of deaths), resulting from the Hiroshima and Nagasaki atomic bomb detonations in 1945 and projected mortality data from contemporary nuclear war scenarios will be addressed. Efforts to prevent nuclear war and proliferation of nuclear components and weapons are also discussed.

H. G. Wells in his novel, *The World Set Free*, published in 1914, predicted a fictional war in 1956 where atomic bombs exploded continuously for days. The weapons were eagerly sought by malcontents and others. In 2007, 93 years later, the Board of Directors of *The Bulletin of the Atomic Scientists* moved the minute hand of its symbolic Doomsday Clock from 7 to 5 minutes to midnight signifying the increased prospect of nuclear war. Buyers and thieves avidly seek nuclear weapons on the open market. Science fiction becomes reality.

So far the Hiroshima and Nagasaki bombs have been the only nuclear weapons intentionally used in warfare. But since then, the destructive power of nuclear (fission) and thermonuclear (fission-fusion) weapons and their delivery systems have dramatically increased. During the cold war, the United States and the Soviet Union had a monopoly on the nuclear bomb market. Today, nuclear states include the United States, Russia, the United Kingdom, France, China, India, Pakistan, North Korea, and possibly Israel. Thirty-two other nations, including Brazil, Argentina, Japan, South Korea, Taiwan, and perhaps, Iran, have sufficient fissionable materials to produce weapons. Not all will seek them. Hardware, fissile material, and the knowledge for constructing weapons are available at the international arms bazaar and on the Internet. As their availability increases, so does the probability of accidental or intentional nuclear weapons detonation, and with it, the prospect of megadeaths, megadying, and megasuffering.

Because of security issues and variations in assessment methods, public data are not totally reliable. However, exact figures are not necessary to illustrate the destructive capability of nuclear weapons. Risk assessments of nuclear war make little sense because the quality and quantity of any retaliatory response is difficult to predict. Only one detonation is necessary to elicit a large, unpredictable nuclear response that might include the use of other weapons of mass destruction (i.e., biological and chemical agents). Nuclear weapons detonation has the potential of omnicide (destruction of humanity by humanity) resulting in megadeath (deaths of people and animals in the millions). It is a form of horrendous death (HD), that is, deaths caused by people. One type of HD is motivated by the desire to kill others. Examples of this desire that could kill millions are intentional environmental assault, terrorism and war, genocide, starvation, use of biological and chemical warfare agents, and the intentional spread of deadly diseases, including new immerging and antibiotic-resistant diseases. Omnicide and HD affect large populations and entail great suffering. Both are preventable.

The First Atomic Bombs: Hiroshima and Nagasaki

On August 6 and 9, 1945, two fission-type bombs were dropped that effectively ended the war with Japan. The first bomb detonated over Hiroshima had an estimated yield of 15 kilotons (KT), equivalent to 15,000 tons of TNT. Its fuel was highly enriched uranium 235 (HEU). The Nagasaki bomb, powered by plutonium 239, had an estimated yield of 21 KT, equivalent to 21,000 tons of TNT. Both were fission-type bombs.

The estimated number of deaths, reported in 1945 following the Hiroshima detonation, was 140,000 or more. The Nagasaki death count for the same period was estimated at 40,000 to 70,000 or more. Most people close to the epicenter died instantly. Many who were further away died of trauma, burns, and/or radiation effects. Long-term deaths were estimated at around 119,000 to 140,000.

Today's Inventory of Nuclear Weapons and Their Capabilities

Today's thermonuclear bombs (combining fission and fusion) have yields measured in megatons (one megaton equals approximately 1 million tons of TNT), and are many times more powerful than fission-type weapons. The average nuclear weapon in the United States is approximately eight times more powerful than the nuclear bomb that destroyed Hiroshima. Yields range from low, used to destroy specific small targets such as buildings and electric power stations, to Russia's big yield of 50 megatons.

Estimates are that about 26,000 to 30,000 nuclear warheads are stockpiled in the world. The United States and Russia possess about 95% of these. As of 2007, the U.S. stockpile contained nearly 10,000 warheads. Russia has about 16,000, France 300, Great Britain and China 200 each, Israel 75 to 200, India 45 to 50, and Pakistan 24 to 48. Of these about 13,000 are deployed and 4,600 of these are on high alert; that is, these are ready to be launched within a few minutes' notice. The combined yield of these weapons is approximately 200,000 times the yield of the Hiroshima fission bomb. Approximately 2 million kilograms of HEU are in global stockpiles. HEU provides the fuel for atomic weapons, nuclear power plants, and nuclear reactors. Plutonium is derived from it and used in fusion-type bombs.

Weapons are now more efficient. Some combine conventional explosives with high radioactivity (i.e., dirty bombs or radiological dispersion devices) and can be carried in backpacks. The Multiple Independently Targeted Vehicles (MIRVs) carry several nuclear weapons and may be delivered by an intercontinental ballistic missile (ICBM) or submarine-launched ballistic missile (SLBM). Such weapons can strike several targets simultaneously. Some weapons are designed to destroy the physical infrastructure, including bunkers and tunnels, where an enemy might hide. The neutron or cobalt bomb is a small thermonuclear bomb that produces minimal blast and heat but releases high amounts of radiation.

Underestimating the Mortality Effects of Nuclear Bomb Detonation

The killing effect of nuclear weapons, including the devastation caused by blast, thermal radiation, and mass fires, are underestimated. That combination is more deadly than blast effects alone. Also underestimated are the health hazards of ionizing radiation. It was only in the 1970s that governments and scientists became aware of risks to the ozone layer.

Radiation contamination from nuclear weapon explosions could linger for years. One study predicted that the detonation of a single one kiloton nuclear weapon on the surface of Detroit during a workday would kill 130,000 people within a 27-mile radius. It would take a minimum of 8 years to return to background levels of radiation assuming no decontamination effort.

Preparation Tactics and Preventive Strategies

Preparation tactics and related programs come into play before or directly after an attack. In the United States, the Department of Homeland Security, the Centers for Disease Control and Prevention, the Federal Aviation Administration, state and local departments of public health, fire and police departments, and others are some of the agencies responsible for preparation. Assessments and field tests show that hospitals, the public health establishment, and other first responders are inadequately prepared to deal with the complex, long-range aftermath of an attack.

Preventive nuclear strategies and processes evolve over time. But suspicion and distrust within and between states are common and increase the possibility of nuclear war. Most bilateral and multilateral policies and treaties designed to prevent acquisition or proliferation of weapons or weapon materials include aspects of surveillance, early detection, verification, and subsequent remediation of the situation. Another mantra is "Trust but verify."

Following World War II and during the cold war with the Soviet Union, Mutual Assured Destruction (MAD) was the dominant strategy of deterrence. It promised massive retaliation. Eventually the Soviet Union and the United States realized that there would be no winner in a nuclear war. Still, MAD remains the dominant preventive strategy.

In 2002, a modified MAD doctrine took the offense. The administration of U.S. President George W. Bush adopted the doctrine of preemptive attack as described in the National Security Strategy of 2002. It assumed the right to preemptively attack an enemy state if there was a perceived nuclear threat. Five NATO generals recently issued a manifesto that allows preventive strikes using nuclear weapons.

Underlying MAD and similar retaliation strategies is an assumed universal fear of death. Its corollary is the drive to live. Preventable, premature, horrendous death is to be avoided at all costs. MAD and other forms of deadly retaliation work as long as the enemy fears death of oneself, loved

ones, and the population at large; fears destruction of their state's culture and infrastructure; and has rational people in positions of responsibility. However, the assumption of universal fear of death is challenged by suicide bombers and other true believers. Killing the invader or hated, repugnant other is reinforced by patriotism, the opportunity for revenge, or theological promise of rapture and martyrdom.

A world free of nuclear weapons is the ideal goal of the antinuclear war, nonproliferation coalition. Diplomacy and other forms of soft power are seen as having more potential to attain peace than military or hard power. The process demands global cooperation to eliminate nuclear stockpiles, fissile materials (especially HEU and plutonium), technology, and the motivation to use weapons of mass destruction.

Part of a soft power and diplomatic approach is to integrate the behavioral sciences and the contributions from disciplines such as cultural anthropology, human development, education, psychology, sociology, thanatology, and theology. Policy makers and practitioners need to integrate empathy and understanding of the enemy's culture into action if nuclear aggression is to be avoided.

Conclusion

Preventing nuclear annihilation and other forms of HD is the overriding health, well-being, and survival task of our time. Eliminating the actuality and threat of HD will require a global effort.

Daniel Leviton

See also Disasters, Man-Made; Genocide; Massacres

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Memorial Day

The origins of Memorial Day (or Decoration Day, reflecting its primary activity of decorating soldiers' graves) in the United States have long been disputed. Essentially a day set aside to commemorate the dead of the Civil War, the debate over its origins—a debate that has now moved online—involves a variety of dates and a broad geographical range of places from Boalsburg, Pennsylvania, to Columbus, Mississippi, and several cities in between laying claim to the "first" Decoration Day ceremonies. In 1966, President Lyndon Johnson officially designated Waterloo, New York, as the birthplace of Memorial Day, because Waterloo had celebrated the occasion in 1866 and had made it an annual event afterward. In 2001, historian David Blight pushed this date back further with a plausible argument that the first Decoration Day had, in fact, been organized by black South Carolinians and white abolitionists, and took place at Charleston's Race Course Cemetery in South Carolina on May 1, 1865.

Orphans decorating their fathers' graves in Glenwood Cemetery, Philadelphia, on Memorial Day

Source: The Illustrated London News. Courtesy of the Library of Congress.

Memorial Day's official incarnation, for the Union side at least, is generally dated to May 30, 1868, with a ceremony at Arlington (which later became the National Cemetery) and credited to the efforts of John Alexander Logan, founder of the Union veterans' organization, the Grand Army of the Republic (GAR). Logan had announced in General Orders No. 11 that May 30 of each year be "designated for the purpose of strewing with flowers, or otherwise decorating the graves of comrades who died in defense of their country during the late rebellion, and whose bodies now lie in almost every city, village, and hamlet churchyard in the land. In this observance," Logan proposed, "no form of ceremony is prescribed, but posts and comrades will in their own way arrange such fitting services and testimonials of respect as circumstances may permit." It was through the efforts of the GAR that Memorial Day became a national holiday. Because it was largely due to the GAR, Logan argued, that "an annual commemoration to the departed heroes of the war had been inaugurated," to the GAR, therefore, fell the "mournful and pleasing duty of perpetuating it." In the aftermath of an internecine war that had cost over 600,000 lives, the need for such a ceremony was strong and universal. Memorial Day became, as historian Michael Kammen notes, "an instant national tradition," and over 31 states had adopted the day as a holiday by 1869.

The pattern that Memorial Day followed can be compared to early Armistice Day ceremonies in Europe. It was primarily a funereal occasion, constructed around and following the precepts of antebellum mourning ritual. A parade to the cemetery frequently led by veterans was followed by the laying of wreaths or flags on each individual grave and later, when the ceremony became more elaborate and, arguably, more political, formal speeches by politicians became a central focus for the proceedings, which usually had a musical accompaniment. By 1891, for example, Memorial Day in New York, as described by *The New York Times,* was a day-long event, beginning at 8:00 in the morning with parades, speeches, and the traditional oration and musical entertainment held in the Metropolitan Opera House, concluding with organized detachments of veterans decorating the various memorials to the Civil War (and to the Mexican War of 1846–1848) around the city. However elaborate it became in the city environment, for much of the 19th and early 20th centuries,

Memorial Day remained focused on the local cemetery and on the graves of the dead, which were decorated with flowers. Civil War veterans were positioned at the center of the ceremony, but public officials, noncombatants, and ministers of religion offered prayers, eulogies, and speeches. Children were a significant element in Memorial Day, as they were in Armistice Day ceremonies. Sometimes their involvement was symbolic of Union sacrifice, as when the children of the Union Orphan Asylum in Baltimore were brought along to decorate their fathers' graves; at other times their involvement had a broader significance and symbolized the importance of Memorial Day as an occasion for reinforcing civic values and precepts among the generations growing up after war.

David W. Blight's study of the complexities of the reunion process in the Civil War's aftermath highlights the reinforcement and refinement of antebellum mourning ritual through Memorial Day. Memorial Day not only revivified the art of the funereal oration, but established a ceremonial occasion through which Northerners, at least, could not only "understand their sacrifice of kin and friends," but identify anew with the idea of America as the "New Israel" and its people as God's elect. Its efficacy in this regard was provided by the new element that the war brought to the concept of America's missionary role, that of redemptive sacrifice in the nation's name. The Memorial Day oration of Union veteran Robert Green Ingersoll in 1882 made this clear in its potted history of the nation, its emphasis on the sacrifices of the Revolutionary generation, and its stirring injunction that Memorial Day was an occasion on which "the story of the great struggle between colonists and kings should be told." The cult of the fallen soldier in America did more than legitimize the war experience; it validated America's national existence. In this sense, expressed most cogently through Memorial Day, the Union dead provided the nation with the most important component of their sacred trust narrative. Through their sacrifice America's existence and its position as the redeemer nation of the modern world was secured.

Alternative Traditions

The celebratory aspect of the North's version of Memorial Day clashed with the more overtly funereal overtones of white Southern ceremonies for the Confederate dead. These ceremonies took place in the context of memorializing not just the fallen, but also the defeat of the Confederacy, and were deliberately set apart from the May 30 event in the North. The rejection by the white South of national Memorial Day celebrations was not surprising. Whereas Northerners could take comfort from the fact that their dead had died in defense of the nation, and accord them full military and social honors, Southerners were left to bury their dead apart, as a putative nation within a nation. The defeat of the Confederacy left its supporters on the sidelines in the new civic nationalism that the North trumpeted so effectively at Gettysburg National Cemetery, Arlington National Cemetery, and elsewhere in the years after the war. Memorial Day ceremonies in the South, although central to the development of the Lost Cause, could only exist as shadows of their Northern counterparts; the unwelcome—but nevertheless persistent and increasingly influential—ghosts at the nationalist feast of post–Civil War American civic ritual.

In both the North and the South, the ceremony conveyed a strong political message from the start, but in the years immediately following the Civil War, the South was constrained in the degree to which it could, overtly, commemorate its dead and the cause for which they had died. Excluded, for obvious reasons, from the burial and associated commemorative ceremonies accorded the Union dead, the bodies of Confederate soldiers were often unmarked and unacknowledged, but not for long. Ladies' Memorial Associations in the white South took on the task not only of commemorating the dead, but of repatriating the bodies of Confederates. This act established, in a real sense, the sacred ground upon which not just Confederate Memorial Day, but the later Lost Cause tradition of the South would be celebrated. Beginning in Columbus, Georgia, in the spring of 1866, Southern ceremonies focused around the "Cities of the Dead," in which the departed were buried in what one editorial termed "their silent houses of clay," but through which the ambitions of the survivors were kept alive.

Unlike in the North, no specific day emerged as the occasion for Confederate Memorial Day, and individual communities selected days that best suited their needs. What they had in common was

a strict outward adherence to traditional, antebellum mourning ritual, which Union onlookers (the Southern states remained occupied by Union troops until 1877) could hardly find fault with. The dominance of women in such ceremonies both followed this pattern and deflected the suspicion—hardly unfounded—that Confederate Memorial Day was as much about keeping Confederate traditions alive as it was about commemorating the dead. In historian William Blair's pithy phrase, Confederate Memorial Day represented "a form of guerrilla warfare through mourning." As in Northern ceremonies, the veteran presence was crucial on Confederate Memorial Day, but in its earliest incarnation, the ceremony had more unsettling military overtones, in some respects, than its Northern counterpart, with the former Confederate soldiers in their old military units, and their prior military leaders (rather than ministers) frequently taking charge of proceedings. This obvious challenge to Union victory quickly diminished after 1867, and Southerners hid any persistent sectional sentiments under a funereal shroud, at least until the Reconstruction ended 10 years later and the last of the federal forces were removed from the South.

Developing a National Tradition

If the North and the South expressed different sentiments through Memorial Day, both nevertheless interpreted the occasion within what Garry Wills has termed the 19th century "culture of death" through which the "place of the dead" provided "a school for the living," and which "made mourning serve life." In Memorial Day's contemplation of the soldier as a sacrifice of war, even in its Confederate variant, the emphasis increasingly focused on the importance of war to the American nation, to its continued existence, and by the later 19th century, the nation's well-being came to reside in the reconciliation of former foes. Memorial Day's emphasis on the "heroic dead" permitted both the North and the South to take from the ceremony reinforcement of their respective positions during the war, and for the South, in particular, offered a route back into the nation via an emphasis on the cost of their sacrifice over its cause. This in itself was cause for concern to some who, in the words of an 1878 editorial, objected to the growing tendency "to obliterate the sharp distinction between battling to save the life of the Nation and fighting to destroy it."

Such concerns over the appropriateness of commemorating the Union and Confederate dead together were soon overtaken by a more general fear that the message of Memorial Day was becoming diluted, less a ceremony to honor the dead than a holiday for the living. It seemed inappropriate to the editor of the Bangor *Daily Whig and Courier* in 1889 that Memorial day in Maine should be the occasion for a baseball game; such a development lacked the necessary "sense of propriety" on a day "set apart for the solemn ceremonies of honouring the memories and visiting the graves of the dead heroes of the Nation." This was not a situation unique to Maine; throughout the nation, even in parts of the South, the decline of ritual observance of the dead on Memorial Day was noted. The ceremony was somewhat reinvigorated after World War I, when Memorial Day was expanded to honor the American dead of all wars. By then even the South was prepared to acknowledge it as a national event, although many Southern states retained a separate day of commemoration for the Confederate dead; in the case of Louisiana and Tennessee, selecting June 3, the birthday of Jefferson Davis, President of the Confederacy.

In the context of 20th-century conflicts, Memorial Day broadened its celebrations to include the wearing of poppies to honor the dead of war, as in Europe, and in 1971, became an official holiday under the National Holiday Act, celebrated on the last Monday in May. The focus on cemeteries and graves remains central, and the official ceremony places flags rather than flowers on the graves at Arlington National Cemetery and a wreath on the Tomb of the Unknown Soldier. Since 1998, candles have been placed on the graves at Fredericksburg and Spotsylvania National Military Park. Echoing the concerns of the later 19th century, however, the persistent sense that the memorializing aspect of Memorial Day has been lost is expressed not only by the veteran community in the United States but by the federal government, each of which has taken a variety of steps since 2000 to reinvest Memorial Day with what is perceived to be its "traditional" meaning as a day of remembrance for America's war dead. To this end, on May 22, 2008, President George W. Bush, acting on a Joint

Resolution of Congress, proclaimed Memorial Day "a day of prayer for permanent peace," to include both a "National Moment of Remembrance" to begin at 3:00 pm on that day and appropriate displays of the American flag (half-mast until noon) on public and private buildings, an overt expression of the continuing centrality of the war dead to America as a nation, and Memorial Day's significance as the sacred ceremony at the heart of the nation.

Susan-Mary Grant

See also Day of the Dead; Memorials; Memorials, War; Tomb of the Unknowns

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Memorials

Studies of memorials for the dead reflect a wide range of interpretations. The Taj Majal, the pyramids of Giza, the Vietnam Veterans Memorial, and the graveyards of Puritan New England, to name but a few, have been approached from architectural, archaeological, aesthetic, and genealogical perspectives. They have also been considered in relation to ideas about status, identity, ethnicity, and social history. However, with these diverse approaches there has often been the embedded assumption that grave markers signify individual interment sites that permanently record the identity of the deceased. In contrast, more recent studies have demonstrated that interment, place, and permanence are not universal, all-pervasive social practices. Rather than frozen in time, cemeteries and memorials have been shown to represent dynamic collections of artifacts subject to the same practical, interpretive, and historical processes as any other cultural text. Furthermore, interment in cemeteries, the marking of individual graves, and the permanent sanctity of grave locations represent just one form of mortuary practice. Thus, recent approaches to the nature of grave markers, cemeteries, and memorials provide us with a more complicated historical and sociocultural perspective by which to understand the relationship between the living and the dead as expressed through material culture.

In many Western countries, the rarity of grave markers prior to 1800 has been commonly attributed to factors of haphazard preservation. However, some studies now suggest that the use of permanent individual gravestones was an occasional practice that became a social norm only after 1800. Prior to that time, individuals whose families sought to maintain continuity and a kindred connection with their ancestors were those most likely to have erected permanent grave markers. Particularly in Europe, interment occurred in a variety of locations, including family courtyards, rural property, and the floors of homes and churches. Final disposition of remains also took place in common graves, such as charnel structures or open garrets. Specifically in Greece, evidence for the practice of secondary burial goes back to the time of Alexander the Great. While European

cemeteries did appear as early as the 12th century, and were often associated with churches or other ecclesiastical structures, it is now understood that a wide variety of local and ethnically based community burial traditions were also practiced.

Graves, Markers, and Cemeteries

The meanings and messages conveyed by grave markers cannot be fully understood without recognition of the communities, histories, and sociocultural contexts in which the deceased lived and died. Gravestone studies, then, highlight a central paradox—death as a fundamental human experience is juxtaposed with death as a contextualized, situated experience. Both the dead and their associated gravestones are inextricably linked to the social circumstances and historical times that create, give boundary to, reify, and express meanings, metaphors, and symbols. As a result, a stroll through a local cemetery is likely to be both a familiar and an alien experience. For late-20th- and early-21st- century Americans, memorial parks filled with bronze markers flush to the ground appear familiar. Likewise, cemetery landscapes constituting slab-shaped gray granite tombstones, sparsely decorated and identifying the deceased by name, are likely to evoke a sense of familiarity. Nevertheless, cemeteries may also contain imposing white marble tablets, elaborate epitaphs that recall vivid imagery, full life-sized statues honoring and lending prominence to the deceased who lies beneath, symbols, metaphoric references, and even styles of lettering that we may be unable to recognize. Because shifts in time and perspective alter our view of these grave forms, their verbal, visual, architectural, and material messages may not be readily evident. Graves and cemeteries are part of the constantly changing social panoply, and death is simultaneously a universal constant and a specifically contextualized experience.

The association of specific gravestone motifs with historical periods was first demonstrated on New England Puritan grave markers. The gradual shift from death's head to cherubs, willows, and other benign images suggests the earlier Puritan view of fearful death became replaced over time by more peaceful views of the afterlife. Further studies have revealed a dramatic increase in the use of individual grave markers throughout Europe and the British Isles from about the 1780s and into the 19th century. This remarkable florescence in the use of simple stones to mark graves seems to have ushered in a new period linking the living to the dead in that a stone became both a public gesture and a place to demonstrate the importance of the deceased to the bereaved.

In more recent periods, trends in the size, material, and configuration of grave markers can be interpreted within the context of expanding Western capitalism. Between 1850 and 1920, for example, grave markers demonstrated a clear reflection of status and social position. However, from about 1920 throughout the 20th century, American cemeteries have reflected a decrease in cemetery marker investment, much greater uniformity, a drastic decrease in large family plots, and the social inconspicuousness of flush bronze markers. For many, this decrease in the visibility of death on the literal and cultural landscape has simply been a reflection of attempts to deny the reality of death. From an ideological perspective, however, these changes indicate a shift from direct expressions of power and status to a masking of status, a denial of inequalities and power relations, and a misrepresentation of the true nature of social relations. Thus, rather than representing mere repositories of stagnant sociocultural norms, we are coming to understand the active role cemeteries have played in American discourses about life, death, and society.

Commemoration, Monuments, and the Historical Dead

A central function of gravestones and cemeteries is to serve as material embodiments of memory. But while memorials appear to be permanent, memories are constantly changing. Therefore, dynamic dialogues between the living, the dead, and grave markers juxtapose complex connections between bereavement, living memories, transforming values, and time. Furthermore, loss of direct remembrance caused by the deaths of successive generations further complicates processes of memorialization and the interpretation of relevant material forms. In addition, historical events, changing collective identities, and shifting interpretations of history can be reflected in our cemeteries and memorials. Cemeteries, then, link the dead to the living so long

as memory among the living is served. Once the surviving memory has likewise taken up residence among the dead, the immediate attachments to individual and community are lost.

Monuments are venues for collective remembrance. Prior to the mid-18th century, monuments were built to and for the elite as a material representation of preordained destiny. These monuments played a part in the constructed linear histories meant to assert the importance of specific times, events, people, and places. However, during the 18th century, the formation of nation-states began to require both the creation of popular common histories as well as the extinguishing of traditionally held boundaries, and the sense of identity began to shift from that of personal ancestry to a collective identity and shared, public heritage. Thus, the rise of national commemorations and the construction of national monuments were purposeful, ideologically driven strategies by which connections to the historic past were broken and new pasts were created.

American Civil War cemeteries further demonstrate the dynamic processes inherent in collective memorialization. The loss of 600,000 soldiers during the war resulted at times in the sorrowful sentiment, "Let the dead bury the dead," because soldiers and civilians alike were overwhelmed by the sheer number of corpses. There was a practical need to dispose of massive number of dead at the sites of battles, skirmishes, prisoner of war camps, and military field hospitals. At the same time, families demanded to know the site of interment for loved ones or to have bodies returned to them for burial. As early as 1861, the War Department issued regulations for recording the dead and burial of Union soldiers, including the marking of all military graves with "headboards." Instructions to secure space near battlefields for interring the dead, and the establishment of the first national military cemetery in July 1862, were also issued. At the same time, a florescence in the embalming of corpses fueled the funeral industry as the demand for the return of the war dead to the families steadily increased. Finally, the rebuilding of an American national identity through commemoration and monuments was galvanized with the assassination of Abraham Lincoln on April 14, 1865, and his interment in Springfield, Illinois, 20 days later.

Later in the 20th century, as the ranks of surviving Civil War veterans thinned, Civil War cemeteries began to transform from memorials of individual lives to places of broad historical significance. Rather than private graves, they became focal points of commemorations and public spaces where collective memories and shared events are given form and meaning. Providing an interesting contrast to the few marked graves of American Revolutionary War soldiers, massive cemeteries and even isolated graves of Union and Confederate soldiers dot the landscape of the Eastern United States. Each marked spot bears witness not so much to individual lives but to the role those lives played in a significant national conflict. These memorials no longer invoke direct memories among the living but bring to mind and materially sanction contemporary narratives about the Civil War. Thus, the events and sacred places created by the conflict of Civil War became ensconced in American discourse, enshrined in our material culture, and forever altered the American landscape.

World War I had a similar, transforming effect on Europe. France alone suffered over 1.3 million military deaths. One response to coping with such vast numbers was to create massive memorials that listed the names of those who had died in specific battles. The building of the Menin Gate to commemorate the battle of Ypres, for example, inscribes 54,896 names. The wall memorial of Tyne Cot contains the names of 34,888 and is surrounded by 11,908 individual graves. The colonnades of the Ploegstreet memorial list 11,447 names; the Duds Corner Memorial forms a walled courtyard with 20,589 names. The Thiepval Monument memorialized the dead from the Battle of the Somme, listing 73,367 names of soldiers whose exact resting place is unknown. Tens of thousands of other names are recounted on similar memorials. There also are the cemeteries, with an estimated 678,000 identical gravestones. In short, the task of memorializing became as massive as the loss of life itself.

A second response was the creation of the Tomb of the Unknown Soldier in the United States and the Tomb of the Unknown Solider in England. The devastating reality of World War I included the vast number of unidentifiable dead and those who could not be accounted for, well over 500,000. Both the Cenotaph—the empty tomb—and the

Tomb of the Unknown Warrior appeared in the 1920s as responses to these losses. Focusing on collective loss, the Tomb of the Unknown Warrior and its variant nationalistic forms created a symbolic space for the return of all war dead represented in the remains of a single individual. Bereavement and mourning became as classless as the remains of the interred solider. Individual loss was now encompassed by public grieving and remembrance. The empty tomb took this hypernominalization of loss one step further by symbolically representing the generic body. The collective loss became represented as the same for all.

Monuments and events commemorating World War II reflect a different sense of loss, resonating with the events of that time. The reconstruction of Germany and Japan, for example, emphasized a forgetting of militaristic activities. Citizens of both countries delayed openly commemorating their war dead well into the 1950s. On the other hand, the victorious nations found the celebration of heroism and sacrifice as important as commemoration, and emphasis shifted to surviving veterans and eventually those who had provided support from the home front. Parades, veteran's organizations, and living memorials predominated over the construction of monuments. Finally, all nations had to confront the horrors of the Holocaust and the massive loss of more civilians than soldiers during the war. Individual memory of those events began to find collective representation in the 1950s and continues to the present.

The Vietnam Veterans Memorial provides yet another distinct example of the commemoration of war, in this case a military conflict that evoked both strong national dissension and ambivalence. The minimalist choice of listing the names of the dead, the absence in the original design of symbols associated with traditional war memorials, and the use of black marble attempt to acknowledge loss of life. The monument's inclusion of names personalizes the sense of loss, and in so doing provides a public space for conflicting feelings and experiences associated with this war to coexist. The meanings of this monument are most importantly conveyed through its uses rather than through the juxtaposition of symbols. The form of operational meaning that began during the early construction phases of the monument, whereby people left gifts and tokens along the wall in memory of loved ones, persists as items continue to be deposited, photographed, collected, and stored. The monument, then, has offered a public venue to express private feelings. How it will serve collective memory once the generation of Vietnam veterans has passed remains to be seen.

Monuments and Politics

Monuments to individuals may also codify explicit, though veiled, political sentiments. Various periods of renewed nationalism in America have witnessed the negotiation and renegotiation of monuments expressing dominant cultural values along with selective forgetting. Groups such as the Mount Vernon Ladies Association, the Daughters of the American Revolution, the Daughters of the Confederacy, and the Emancipation Group, for example, each sought to shape collective memory of the past. Specifically, the Emancipation Group sought to commemorate the "Freedman" as the personification of the Reconstruction ideals of the Fourteenth and Fifteenth amendments. At the same time, although both Northern and Southern groups focused increasingly on the heroic deeds of local heroes, the wording on monuments emphasized the Union in the North and state sovereignty in the South.

The sole monument to emancipation was the Freedman's Memorial, designed by Thomas Ball, and funded entirely by the contribution of free blacks. After years of wrangling, and the failure of earlier designs, Balls' monument was erected in Washington, D.C., on April 14, 1879, the 11th anniversary of Lincoln's death. Intended to convey the self-determination by which slaves actively participated in breaking the shackles of slavery, the memorial instead portrays a slave kneeling at the feet of Lincoln having just realized his chains were broken. Frederick Douglass, who delivered the oration at the memorial's dedication, in fact objected to the slave's kneeling posture as unmanly, manliness representing, to Douglass, the opposite of slavery. Thus, the intent to express freedom in the Freedman's Memorial is ultimately subverted through the positions of its figures. The dominant representation of Lincoln further subverts the status of Freedmen.

Monuments remain powerful symbolic elements in our landscapes precisely because they are built

to endure, distilling a representation about the past long after the events, debates, and disputes that created the monuments have been forgotten. Perhaps precisely because monuments appear inert and permanent, these features are also subject to continual reinterpretation. The rapid tearing down of the Lenin and Marx statues through old Soviet Bloc countries in 1989 seemed to resonate with the removal of statues of Tsar Alexander III during the Bolshevik Revolution, which brought Lenin and Marx to prominence.

The public spaces shaped by monuments and the individual they commemorate both mirror and are shaped by societal values. They are forums that articulate collective memory and popular consensus. They are also cultural sites in which the memorialization of selective individuals galvanizes debate and thus reflects the ways in which the past is contested. The creation, design, construction, modification, and destruction of monuments are neither a permanent testament to the past nor a static process. Levinson notes, "To commemorate is to take a stand, to declare the reality of heroes or heroic events worthy of emulation, or less frequently, that an event that occurred at a particular place was indeed so terrible that it must be remembered forever after as a cautionary note." It is this process, rather than the inert structures themselves, that lend meaning both to monuments and to the events they commemorate.

Ann M. Palkovich and
Ann Korologos Bazzarone

See also Bereavement, Grief, and Mourning; Cemeteries; Cemeteries, Unmarked Graves and Potter's Field; Cemeteries, Virtual; Communal Bereavement; Memorials, Roadside; Tombstones

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Memorials, Quilts

Quilts have for centuries been one of the most consistent forms of textiles used in the home. Through the centuries, quilts have also served multiple purposes—as bedcovers, of course, but also as shrouds or coffin liners or covers; sleep has always been closely associated with death. Historically, the making of quilts was often a shared activity, providing women in a community with sociability and the opportunity for creative expression, a welcome—and productive—diversion from the more isolating and physically demanding tasks of housekeeping. A new availability of endlessly patterned and colorful commercial fabrics for use in dressmaking and upholstery helped to spur a lively flourishing of creative expression in 19th-century America well beyond utilitarian purposes. Quilts became a way to celebrate or commemorate significant events in one's personal life or in the community or nation. A particular type of commemorative quilt that can take many different forms is the memorial, or mourning quilt, which memorializes the deceased, whether an individual or a community of individuals.

Memorial quilts largely fall into two categories: those honoring an individual and those commemorating a community of individuals.

Mourning Quilts in America

With the elaboration of mourning practices and a new emphasis on memorialization in America in the 19th century, quilts became one of the most intensely personal ways to express grief, loss, and memory. Mourning customs, directed particularly toward women, dictated everything from the color of a widow's clothes and jewelry and the specific length of time she was expected to mourn, to the size of the black border around her stationery. As part of their education, young women created embroideries and samplers that memorialized a deceased family member or friend, following accepted conventions of needlework.

The most personal expressions of loss are usually found in memorial quilts for individuals. In the 19th century, with high rates of infant and child mortality and frequent widowhood, mothers and wives often found solace in creating quilts to honor their loved ones. Designs typically used the colors of mourning—black, white, and shades of gray, possibly with shades of purple as well—with black borders, similar to the stationery and handkerchiefs widows used. Some designs used symbols and motifs found on gravestones—for example, the lyre with a broken string or the funerary urn. These quilts could replace the more brightly colored bedcovers in the bedroom, at least for a while.

Another personal expression of mourning was the "memory quilt," in which a quilt was pieced together from the deceased's clothing. Based on documentary sources, it appears this particular type of quilt was often made by women mourning other women—pieces of the deceased's dresses, which themselves had typically been made from brightly colored calicoes and cottons, were joined together, with religious sayings or sentimental verse memorializing the deceased embroidered in the middle white square. Occasionally these quilts also acted as albums for friends and family, who included poems, sayings, and signatures, attesting to their grief and love for the departed. Memorial ribbon quilts incorporated pieces of ribbons from the deceased's funeral services. The making of the quilt provided a therapeutic and comforting way to work through grief, while the finished quilt acted as a "memory" of, and connection to, the deceased. The tradition of incorporating pieces connected to the deceased's life or pictorial symbols relating to mourning and loss seems to have been practiced in most communities, regardless of ethnicity, race, or socioeconomic class during the 19th century.

Quilts as Memorials

The other major type of memorial quilt is one that commemorates an event that has caused the death of large numbers of people or that has caused mourning on a communal, or even national, scale. The Civil War, a watershed event in American history that disrupted the very fabric of American society and life in its enormous loss of life and devastation, was the direct cause of the creation of thousands of quilts memorializing individuals or even regiments. In 1986, the *Challenger* space shuttle disaster spurred many quilters to create their own expressions of shock and grief. More recently, the events of September 11, 2001, have provided the impetus for numerous individuals and groups across the country to create memorial quilts commemorating that day and its aftermath, as the event in recent history caused mourning on a previously unimaginable nationwide scale. The Mothers Against Drunk Driving (MADD) quilts are just one example of a memorial project inspired by personal loss that helps to raise public consciousness about avoidable tragedy. Similarly, the Iraq War has been the inspiration for numerous memorial quilts, inspired by individual deaths or by larger concerns about the devastation and tragedy of warfare.

Probably the most publicly visible and famous quilt today is the NAMES Project Quilt, better known as the AIDS Memorial Quilt, which commemorates the victims of the AIDS epidemic. Begun in 1987, the quilt is constructed of cloth panels, individual "quilts" of 3 by 6 feet, which are joined in blocks or sections of six panels. The panels are made by friends and families of the deceased, and are highly personal expressions, ranging from simple to elaborately decorated, often containing mementos and souvenirs of the deceased. The AIDS Memorial Quilt grew quickly in size and the panels now number more than 40,000. Because of its enormous size, only sections of the AIDS Quilt

can be exhibited at any given time, often in cavernous settings (for example, a warehouse or a football field), leading to controversy over whether it really can be called a quilt, or an artifact (never in one piece) that has lost all reasonable association with the more personal, intimate proportions of a human body. Regardless of this disagreement, the AIDS Quilt has clearly provided a mode of expression for memorialization on a national and even international scale, and a way to remember thousands of victims of AIDS and AIDS-related diseases. Panels continue to be added to the AIDS Quilt, the largest ongoing community arts project in the world.

Memorial Quilts in Other Cultures

Other countries and civilizations have practiced indigenous forms of quilt making as part of mourning and burial rituals. The people of Native American tribes, Europe, Tahiti and Polynesia, Central and Southeastern Asia, the Middle East, and Russia all have documented traditions of making memorial or burial quilts to commemorate the deceased. Often these are made in traditional patterns associated with mourning, using specific colors, types of cloth, and motifs.

Memorial Quilts Today

Even as the preparation and care of the deceased's remains was increasingly taken over by commercial funeral parlors and hospitals in the late 19th century and the care of the dead became a matter for professionals, the making of quilts retained their important function as connections to the deceased. Today, whether as makers or observers, memorial quilts still bring people together at times of loss and tragedy to honor the departed and to mourn as part of a community or a nation.

Elise Madeleine Ciregna

See also Bereavement, Grief, and Mourning; Clothing and Fashion, Death-Related; Memorials

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Memorials, Roadside

Roadside memorials may be created by individuals or groups spontaneously or as a planned activity. Memorials often function as a way to communicate with the deceased as well as a means through which mourners express their grief while also memorializing the deceased. In the United States, such practices have been documented in newspaper accounts and diaries from the 19th century, as well as literary sources and newspapers in the 20th century. This practice has been reported in a number of countries around the world, including Mexico, Canada, Greece, and Australia.

Roadside memorials mark the site where a fatality has occurred. Although usually the result of an automobile collision, the fatality may have resulted from other causes (such as murder or from natural causes while traveling or exercising).

Memorials are utilized by mourners as a way of coping with deaths that are sudden and tragic in nature. The most common components of the memorial are a cross and artificial flowers, although numerous other artifacts may be utilized as well. Some of the functions served by these memorials are to prolong the memory of the deceased in a public place, to communicate with the deceased, and to transmit a message to society, serving as both an expression of mourning and an attempt to warn others of the dangers associated with driving.

History

The placing of markers at the site of a death is reported to date back hundreds of years to Europe in general and to Spain in particular. Controversies related to roadside memorials typically revolve around the rights of mourners to place a private marker on public lands or on public right-of-ways.

In this era, the deceased are not buried at the site, but the marking is a notice that something

significant happened on that site. Roadside memorials almost always hold some religious significance, although that significance is more likely to be general in nature rather than a religious ritual prescribed by one's faith. An early practice in England involved cutting in the stone or scratching in the dust the sign of the cross at the site of an accident or a murder. This practice was not only to pacify the ghost of the deceased, but to keep the ghost from haunting the location, and to allow passersby to continue to remark the spot. For example, in Mexican Catholic tradition, the memorial marks a spot where someone died without receiving Last Rights, and thus serves as a reminder to passersby to stop and pray for the deceased.

The use of crucitas (or little crosses) has been traced back to Spain and the conquest of the New World. In Spanish tradition, crosses by the side of the road marked the resting place for those who were carrying a coffin to be buried. The tradition of placing roadside crosses to mark the spot where an untimely death occurred has survived in South Texas and followed Mexican-American migration to other parts of the country. Not limited to Mexican or Catholic tradition, death memorials have also been used by the Tohono O'odham tribe of southern Arizona to mark the locations of violent or "bad" deaths for several decades. Indeed, roadside memorials are placed by a wide variety of people representing various religious and cultural backgrounds.

Functions

Roadside memorials serve a number of functions both for the bereaved and for the community. Placing a roadside memorial may serve as a mourning ritual in which the bereaved attempt to find meaning in their loss by warning others of the dangers associated with driving. Such memorials may be placed spontaneously while visiting the site, or the result of meticulous planning, to be placed at some later time.

Although some of these memorials are constructed by a group of family or friends, they may well be the act of an individual as they mourn their loss. Though a private act of mourning, the roadside memorial is in a public place; however, the community-sanctioned site for a memorial is in the cemetery. Roadside memorials may also be placed or contributed to by people who may not have participated in the planning of traditional mourning ceremonies, including friends, colleagues, community members, or relatives.

The artifacts left at roadside memorials are similar to those left at other spontaneous or impromptu memorial sites, including both traditional and idiosyncratic mementos. Examples of traditional mementos include a cross, flowers, praying hands, candles, and stuffed animals, or artifacts more idiosyncratic in nature such as cigarettes, beer cans, shoes, articles of clothing, or personalized written messages. Artifacts, such as a cigarette, may represent an activity previously shared by the deceased and the bereaved; however, in many cases, the meaning of the mementos is known only to the person placing the item.

Benefits for Mourners

Roadside memorials are not limited by traditional schedules of mourning or ritualization. As soon as a fatality is made public, artifacts in honor of and in memory of the deceased are placed at the site of the tragedy. Whereas family members will be invited to the hospital or funeral home for preparations and decision making, people not included in this process can conduct their own memorial rituals by visiting the site of the fatality, attempting to understand how the tragedy occurred, and leaving personal mementos at the site. Roadside memorials are often put into place before the public ceremonies are held, serving as a gathering place prior to the day of the funeral as well as afterward.

A roadside memorial site is a noninstitutional site, in contrast to the cemetery with rules and regulations regarding memorializing behavior and staff to regularly remove unacceptable artifacts. By contrast, the roadside memorial site may not be restricted by such rules or have oversight by staff who can insure compliance.

The bereaved may visit the site at any time; however, certain times of the year are common for visiting these sites, such as the holidays of Christmas, Easter, Halloween, Thanksgiving, Valentine's Day, and Memorial Day. Other special days for visiting the site include the birthday of the deceased and the date of the death.

Another important contrast to the cemetery is that a roadside memorial site does not house

physical remains. Perhaps there is also more of a mystical or spiritual element to the site where the tragedy occurred, because survivors are not faced with the awareness that the physical body is there in the ground. They can focus more on the fact that the person's spirit departed here and, according to some religious and cultural traditions, may in some ways still be present in that place. Another possibility is that in the face of feelings of helplessness, the memorials allow the bereaved to "do" something for the deceased.

Another function of roadside memorials is that they may include a political-social message about the cause of death and/or the implications of the death. These artifacts show the communicative function of the sites as a warning to others about the dangers of this location or of activities such as drinking and driving. This function leads logically to a discussion of controversies surrounding memorials placed by the side of the road.

Controversies

The major controversy surrounding roadside memorials revolves around the legality of placing them on property not owned by the person placing the memorial. More often than not, the memorial is on land owned by the state and thus certain limitations regulate how the land can be used. Maintenance of this roadside space is one logistical issue related to memorials, such that more time and attention is required to keep vegetation under control and thus maintain this space in a safe manner. Memorials overgrown by vegetation may be obscured from view, increasing the likelihood of being struck by a maintenance vehicle. In addition, the size of some memorials makes them a potential hazard if struck by another vehicle. Some memorials become quite large, but whether large or small, if not maintained the memorial becomes an eyesore. Other maintenance issues are that some of the materials left at memorials will decompose, such as a pumpkin or jack-o'-lantern and artifacts made of cloth or paper. Due to the effects of the weather, some materials need to be repainted to serve their memorializing function well. Some mourners use spray paint to write in large print across the road in graffiti-like fashion, which may be banned outright or become unsightly. Attempts to regulate memorials have included outright bans of such memorials, allowance with certain limitations on size and construction materials, and the placement of a state-sanctioned memorial upon request by the family of the deceased.

Some observers will criticize roadside memorials because they are tired of being reminded of the fatality every time they pass a certain place and that they think people should move on with their lives. The opinion of the majority of people appears to be in support of the right of mourners to place roadside memorials.

Logistical advice about roadside memorials includes avoiding the use of laminated wood, pressed wood, or particleboard, as these materials succumb to the effects of the weather quite rapidly. Metal or concrete markers may be a hazard to vehicles and passengers. Whereas fatalities have occurred to people visiting roadside memorial sites, other hazards include poisonous flora and fauna. The safety of mourners should be of paramount importance.

Jon K. Reid

See also Accidental Death; Bereavement, Grief, and Mourning; Christian Beliefs and Traditions; Grief, Bereavement, and Mourning in Historical Perspective; Memorials; Monuments; Spontaneous Shrines

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Memorials, War

War memorials have developed throughout time and have varying purposes within different historical eras and societies. Initially the purpose of war memorials was not memorialization at all but to commemorate a victorious leader. This tradition began in ancient times and continued through the early modern era. During the modern era, war memorials began to be constructed to pay homage to particular wars or battles. Contemporary war memorials have become part of the historical discourse of the wars they address and reflect national identity, define collective memory, facilitate traumatic healing, or are locations for ritual ceremonies.

War memorials are generally monuments, which are freestanding objects that serve the singular dedicatory purpose of memorializing war in a designated space that becomes sacred. They can, however, be buildings, locations such as battlefields, museums, or collections of memorabilia, or resources dedicated to sustaining the memory of a particular war or groups or individuals who fought in a war. In some cases, war memorials are placed on the site of a significant or decisive battle or at locations where many soldiers fell. In other cases, memorials are situated on public land within municipalities that wish to recognize the sacrifices of its residents, or in a nation's capitol as homage to incidents of national involvement that occurred elsewhere. War memorials that list or highlight individual deaths caused by war are generally a 20th-century phenomenon due to the perpetuation of some of the most wide-scale wars in human history.

Historic Foundations of War Memorialization

In ancient civilizations, the most attention was paid to the leaders of wars, and soldiers' deaths were marked in a similar manner to the death of any individual at the time. In ancient Greece, particularly during the Geometric period, large ceramic vases were used as grave markers, but those of soldiers were inscribed with distinguishing figures that storied the warrior's funeral. The Dipylon Vase (800–700 B.C.E.), for instance, a vessel over three feet high, depicts registers of schematized horses, soldiers, weapons, and shields with the dead warrior in the center rendered as a rudimentary solid figure laid horizontally amid the procession. A woman raises her arms in an iconic representation of mourning. Like most gravesites and markers in ancient Greece, objects such as the Dipylon Vase were devoted to single individuals, and the sites were used as gathering places for commemorations and feasts to which family and friends returned periodically.

Roman society also commemorated individuals at gravesites or in catacombs, rather than groups of individuals or wars. Victories in the Roman Republic were marked by the emperors themselves, usually through monuments glorifying their real or imagined prowess in leading armies in conquests. The exploits of each ruler are typically recorded on large triumphal arches such as the Arch of Titus (81 C.E.) and the Arch of Constantine (312–315 C.E.). Arches were generally singular like the Arch of Titus, or could be triple, like Constantine's, but all were of colossal size (approximately 40 feet wide and 70 feet high, respectively) and meant to emphasize the victories of the rulers rather than the might of the individuals who comprised the armies that served him. Another form of commemoration was a column, such as the 125-foot-high Column of Trajan (106–113 C.E.), in which the Roman leader had his exploits carved in a spiral around a 13-foot-wide column. Such practices are followed throughout European civilization thereafter, in which leaders are often monumentalized on horseback and without note of the many soldiers who served him.

Memorialization of War in the Modern Era

Shifts in war memorialization began to occur with monuments such as the 165-foot-high, 148-foot-wide, 72-foot-deep Arc de Triomphe in Paris, commissioned by Napoleon in 1806 and completed in 1836. This memorial was designed by Jean Chalgrin with iconographic reliefs of nude French youths fighting Germanic warriors and based on the Arch

of Titus. Another example is Nelson's Column (1840–1843) in London's Trafalgar Square, a 151-foot granite column designed by William Railton in 1838 and topped by an 18-foot sandstone statue of Admiral Horatio Nelson by E. H. Baily. Neither memorial lists the names of individual soldiers, and the forms follow Roman aesthetic precedent. As a precursor to the memorialization of individuals and the tradition of memorials that emerges in the 20th century, the American Civil War (1861–1865) became an important moment in history because the losses were so personal (often with different members of families fighting each other depending on their allegiance to the North or South), widespread, and devastating to the fabric of the fractured American society that many small memorials and large commemorations of battlefields resulted.

However, the modern concept of memorialization began to take note of and acknowledge individual losses from war. This coincides with technological advances in 20th-century war waging in which guns, mines, and bombs could inflict much greater damage on a larger number of individuals at once than swords, spears, or even muskets had in the past. In addition, a soldier was less likely to see his enemy or have as much warning of attack. In essence, as war became less personal and more catastrophic, attempts to commemorate it and the individuals who died while waging it became more important and widespread.

During the First World War (1914–1918), also know as the Great War or the War to End All Wars, which took place primarily in Europe, memorials were constructed in many locations, often small groups or villages taking it upon themselves to commemorate the loss of their fathers, brothers, husbands, and sons or with soldiers creating ad-hoc memorials on the site of a comrade's death in enemy territory. This was partially an antidote to the mass graves that had to be administered on battlefields and away from the soldier's homes because many soldiers could not be identified or have their remains returned home in sufficient time for proper burial. An example of a combined type of memorial is the Thiepval Memorial, dedicated on July 31, 1932, and the largest British war memorial in the world, containing the names of 73,357 officers of Great Britain and South Africa who died in battle at the Somme in France between July 1916 and March 1918. The form of the memorial is a 150-foot-high archway with legs that sit atop two other archways (123 by 140 feet) and surrounded by a cemetery of white crosses.

After World War II, many memorials continued to be built on battlefields throughout Europe. In addition, local towns continued to commemorate their war dead. Local governments erected "honor rolls" or lists of names in front of city halls or in central town squares. Although much of World War II took place in Europe, it marked the prominence of air power, the introduction of the atom bomb, and the use of large weapons and machinery. Much of American society was invested in the war in a way unlike past conflicts because of the Japanese attack on Pearl Harbor, the rationing of goods and supplies, and the inhumanity of the Holocaust. However, monuments rather than memorials prevailed in the aftermath of the war, the intent being primarily to glorify American victory. The United States Marine Corps War Memorial (1954), for instance, depicts the battle of Iwo Jima in Japan, one of the most decisive during World War II. And although the memorial is dedicated to all the marines who have given their lives in battle, it exemplifies the successful completion of a mission rather than the sacrifice of life that went into achieving it. Based on a Pulitzer Prize winning photograph of five marines and a navy corpsmen raising a flag atop the island mountain, sculptor Felix DeWeldon's 32-foot bronze figures raising a 60-foot flagpole was placed atop Horace Peasley's 10-foot base containing inscriptions of all of the marine corps engagements since 1775, when it was founded.

Contemporary War Memorials and the Significance of Design

The most marked shift in memorialization and the most significant war memorial to be constructed, however, is arguably the national Vietnam Veterans Memorial in Washington, D.C. Although national memorials were generally constructed with public funds by governments through official processes, the Vietnam Veterans Memorial was funded by private donations obtained by a group organized in 1979, the Vietnam Veterans Memorial Fund, which consisted mainly of Vietnam veterans and their families. The design of the memorial was

selected through a national competition whose parameters insisted that the final design be apolitical in nature, contain all of the names of the dead and missing (currently 58,249), be reflective and contemplative in nature, and harmonize with its surroundings. Congress approved its situation on the National Mall between the Lincoln and Washington memorials. Twenty-one-year-old Maya Lin's design was selected from over 1,400 anonymous entries, but its minimalist form, consisting of two black granite walls to meet at a vertex, was controversial, and a figural sculpture group of three men as well as a flagpole were added near its entrance.

Each of the memorial's two granite wings is 246 feet, 9 inches long, and they meet at an angle of 125 degrees, 12 minutes, and are edged against a grassy embankment. At its shallowest, the east and west tips, the memorial rises no more than 8 inches, with a height of 10 feet, 3 inches at the center. Each wall consists of 70 numbered panels inscribed with names that are listed chronologically in order of death date, beginning and ending at the vertex. Each panel is 3 inches thick and 40 inches wide and contains from 1 to 137 lines with 5 to 6 names per line. The names are .53 inch high and .015 inch deep and are listed in a phone book style directory located at the ends of the memorial. Each entry gives the full name, date of death, branch of service, and hometown of each individual, along with the panel number and row where he or she is located on the memorial. Next to each name a diamond marks the confirmed dead, and a cross designates each of the 1,300 missing. If missing in action (MIA) remains are returned, the cross is changed to diamond.

The nonconfrontational and nonnationalistic aesthetic of "the Wall," as it became known, immediately resonated with visitors and veterans upon its dedication on November 13, 1982, and it became a backdrop and destination for ceremonies, parades, commemorations, and healing, particularly during Memorial Day and Veterans Day. In particular, the memorial served as a magnet for veterans suffering from post-traumatic stress disorder because it finally, after the huge controversy surrounding the Vietnam War, which included protests, flights from the draft, and general unrest, brought the subject of America's lost war out into the open. It also served to commemorate the men who fought and died in the war, who had arguably not been adequately recognized by the public or government for their service.

Ironically, considering its humble and grassroots beginnings, the Vietnam Veterans Memorial has become the most visited commemorative site in the nation. At the Wall, individuals trace the carved names with their fingers, take rubbings of the names to get an imprint of the incised letters, use the location as a place for meeting former comrades, family mourning, or connecting surviving soldiers with the families of the dead. Objects such as photographs, medals, old army boots, teddy bears, poems, and even a vintage Harley Davidson have been left there, and the memorial has inspired literature such as *In Country* by Bobbi Ann Mason and a Hollywood movie by the same name, as well as events such as Rolling Thunder, a Memorial Day motorcycle ride for the purpose of drawing attention to MIA/POW causes.

The Vietnam Veterans Memorial has become the prototype for memorialization, not only for war memorials, but memorials to tragedies such as the Oklahoma Federal Building bombing, the memorial to September 11, 2001, the Columbine High School shootings, cancer memorials, and memorials to individuals. It also sparked a battle over the National Mall as a site for recognition of other wars through public memorials. Those who had fought in the Korean War also felt neglected and deserving of a memorial. This prompted World War II veterans, who, despite having been greeted upon their return by victory parades unlike the largely ignored veterans of the Korean or Vietnam Wars, to feel that they too deserved a memorial on the National Mall.

The Korean Veterans Memorial design was selected by competition from a concept initiated by a group of architects from State College, Pennsylvania, but was significantly revised by the firm Cooper-Lechy Associates for its execution. The purpose of the memorial is to commemorate the 1950–1953 conflict between North and South Korea (which is most well known from the television series *M*A*S*H*). It includes a field of bronze figures (by Frank Gaylord) making their way next to a wall etched with the faces of soldiers (by Louis Nelson), and also incorporates a pool of water, flag, and inscription honoring the veterans. The style of the national World War II Memorial is

imperialist in nature, taking over the middle center of the National Mall. It has symbolic stars, pylons with the names of regions where the war was fought, and the states that had contributed men to serve. Construction began in 2002, and it was dedicated on May 29, 2004. It was executed by a large team of architects, landscape architects, and carvers, and was based on a design submitted by Friedrich St. Florian. Relief sculptures line either side of the wide entry walkway and the large shallow fountain in its center acts as a recreational place for individuals rather than a solemn location of commemoration, mourning, and remembrance, as had become the tradition in war memorials. Rather, this returns to earlier imperialist gestures of Rome and Europe.

Kim S. Theriault

See also Cemeteries and Columbaria, Military and Battlefield; Communal Bereavement; Funerals, Military; Grief, Bereavement, and Mourning in Historical Perspective; Memorial Day; Monuments; War Deaths

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Mesoamerican Pre-Columbian Beliefs and Traditions

Strictly speaking, pre-Columbian cultures refer to American Indigenous groups who thrived on the American continents until the arrival of the Conquistadors (1492) and the posterior European influence. However, the term has a broader application due to the persistence of some native traits after the European conquest and colonization and the incorporation of the native population into the practice of Catholic doctrine and European culture. Even today, examples of this case of acculturation remain alive in some areas of Central and South America.

The main contributions of pre-Columbian beliefs and traditions to the study of dying, death, and human experience include the meaningful relationship that the living maintain with their dead ancestors and deities, as well as the methods employed to sustain such relationships. Many aspects of everyday life were affected by the cult of death, for instance, frequent placement of votive offerings, organization of war to collect captives for sacrificial purposes, promotion of superstitious beliefs, and more importantly, organization of fiestas and rituals that surrounded all celebrations of death. It was believed that an anticipated death was necessary for appeasing gods and benefiting the life cycle of the community, hence the imprint of sacrificial practices.

This entry focuses on relationships among the living and the dead ancestors, treatments of the body, beliefs in the afterlife, and notions of death and decay of pre-Columbian societies. Various sources of information allow an interdisciplinary approach, based mostly on archaeological evidence and ethnohistorical narratives (16th and 17th century chronicles written by Spaniards). It is possible to know the material culture used and the activities related to the rituals and ceremonies that surrounded death.

Mesoamerican Pre-Columbian Societies

Conceptions of death in Mesoamerican societies are mostly known because of practices of sacrifice and were mainly promoted by gruesome descriptions of 16th-century ethnohistorical accounts, which describe large piles of human hearts offered to deities in order to calm their thirst for blood. Furthermore, archaeological remains complement this view, due to the proliferation of temples (where sacrifices took place) and iconography representing morbid features, such as skulls, skeletal figures, human organs, deities of death, and captives of war. Spaniards considered ceremonies of sacrifice shocking spectacles, which led Mesoamericans to gain a reputation as violent and bloody societies, a fact that eclipsed interest in explaining the reasons why sacrifice was organized in the first place.

The twofold notion of reciprocity and cyclical time characterize Mesoamerican thought. On one hand, Mesoamerican societies shared the belief that their gods sacrificed themselves to create humankind. Hence, humans are permanently indebted to their creators, and failure to repay such debt would result in the devastating fury of their gods and in the end of human life and goodness. Priests constantly placed offerings of food in temples and performed rites of bloodletting (i.e., perforation of several parts of their body to induce intentional bleeding in the tongue, face, and/or penis). On the other hand, the notion of cyclical time is embedded in the idea of limited goodness. Thus, life has to be periodically renewed by the gods' blessing. These two pillars of Mesoamerican thought contributed to the development of profoundly religious societies to whom the cult of their deities was a warranty of their own survival. Paradoxically, the machinery of death was nothing but a mechanism to regenerate life and promote goodness and fertility within the society.

Aztec human sacrifices were performed on occasions of religious and political significance and were executed by priests of the highest rank. Most of sacrificial victims were war captives, to such an extent that the main objective of war was not the destruction of the enemy on the battlefield but the acquisition of the captives; thus, war was called "flower war" or "flowery war." Codices graphically illustrate details of the capture of victims and later sacrifice. Sacrificial victims were considered offerings and were used to reciprocate debts previously obtained. In addition, multiple sacrifices were also performed before the erection of buildings as is illustrated by the many sacrificed individuals found in the foundations of the Feather Serpent Temple of the city of Teotihuacan, possibly with the purpose of securing a sacred basis on which the temple rested.

The idea of an anticipated death was in some instances a good omen. For example, warriors who died on the battlefield and women who died in child labor were believed to enter the netherworld straightaway, and were even considered good deaths. Mesoamericans were used to coexisting with death, and it is not surprising that death was incorporated into many areas of their lives. For example, the cult of ancestor worship is a living tradition in many regions of current Central America. Ceremonies organized in honor to the god of death or god of the underworld, Mictlantecuhtli, were celebrated in the 9th month (Miccailhuitontil) of the Mesoamerican calendar, which coincided with the end of July and the beginning of August of the Gregorian calendar. Even if Indigenous communities adopted the Catholic doctrine, they continued to practice some traditional rites, among which the cult to the god of death was the most popular. This celebration was so popular that it was eventually incorporated into the Catholic calendar during the days of all souls and all saints (November 1–2), so that the celebration of the day of the dead, better known as *Día de los muertos*, had a pre-Columbian origin and is a living testimony to ancient celebrations. In fact, it is a good example of acculturation of the pre-Hispanic and European traditions. Rather than being a lugubrious celebration, the day of the dead is an occasion to gather with relatives and friends and is tinted by a festive atmosphere that stands out for celebrating life and communion among the living and the dead ancestors.

South American Pre-Columbian Societies

The study of mortuary evidence focused for a long time merely on chronologies, grave contents, treatment of the body, type of sites of burial, and especially on socioeconomic status, so that lesser attention was paid to question how mortuary practices functioned in each culture and to the study of social aspects of death. Nowadays, two main areas of interest are studied to explain the context in which pre-Columbian mortuary evidence of the South American region are found: the importance of the preservation of the corpse and the disposal of the burial.

South American regions have ideal environmental conditions for preservation, due to the dry coastal deserts and frozen mountains. Consequently, it is not surprising to find many mummies in good conditions. Ancient inhabitants of the region must have realized that situation too, hence the interest in using such conditions in favor of preserving the corporal existence of their dead by practicing mummification. The Chinchorro culture (ca. 6000 to 500 B.C.E.) provides examples that constitute some of the earliest evidence of mummification in the world. Adults and

children wore clay masks, and in some occasions the limbs were molded in clay too. These clay-molded mummies reflect a deliberate intention to turn the bodies as rigid as possible, perhaps with the purpose of transporting them.

Greater efforts were made to study the various techniques and procedures of mummification, such as natural and artificial mummification, methods of evisceration, removal of organs and stuff used for filling the corpse. However, little is known about the role played by mummies in their societies, apart from the documentation found in the ethnohistorical narratives. Spaniards regarded mummies as pagan idols and/or diabolic manifestations that incarnated the old beliefs and traditions, so that mummies were taken to represent obstacles to the process of evangelization and adoption of the Catholic doctrine. For instance, Muiscas (pre-Columbian society of Colombia) secretly continued mummifying some of their individuals long after the Colonial period; and by clinging to this practice, they resisted the imposition of an alien culture. Mummies were placed in caves that became sanctuaries of adoration, to whom Indians paid visits and presented offerings.

The practice of mummification has received a series of interpretations. In fact, a great emphasis was put on the relationship between mortuary remains and socioeconomic status, to such an extent that this view limited the study of further aspects, beginning with the reasons why mummification was preferred over other types of treatment of the corpse. An example of that is the Inca practice of curing the bodies of their rulers, which was merely interpreted in terms of assessing political hierarchy, and did not address topics associated with the mortuary disposal of rulers, such as insights into death, decay, the significance of preserving the corporal existence and postponing the social death of the leaders.

Individuals were mummified for sacrificial purposes too, as the Inca ceremony of *Capacocha* illustrated. This ceremony was performed in times of crisis, such as earthquakes, epidemics, droughts, or after the death of an Inca Emperor; and it involved the sacrifice of a child, which bestowed him and his family with high status. The child sacrificed was often the chief's progeny. On the day of the sacrifice, children were fed with *chicha* or an alcoholic beverage to ease the pain of the cold and altitude, as well as to be able to cope with the fear of their own deaths. However, skull fractures found in the sacrificed children indicate that children possibly suffered a violent death and they did not die due to exposure to the elements.

The practice of sacrifice is also represented in the iconography of statues and pottery. Mochica pottery is widely known because of the drawings printed on their vessels. For many years, it was thought that the scenes of dismembered and decapitated bodies were representations of myths and/or descriptions of battles between deities. Recent evidence from archaeological research in Huaca de la Luna has proved this assumption to be wrong and, on the contrary, it has revealed that people died due to violent causes. Skeletal remains present fractures of the backbone, skulls, and other bones, and it is likely the representation of large group sacrifices of captives; that is, individuals had their hands tied behind their backs. These discoveries show that iconography can be interpreted as historical testimonies rather than merely esthetical recounts of imaginary events.

In spite of the interest that Mesoamerican and South American pre-Columbian societies engender, the biggest challenge is to overcome the culture-bound limitations attached to current interpretations of the archaeological remains and ethnohistorical readings. This issue highlights the importance of learning about native ideas of death and life, profane and sacred spaces and behaviors. Questions about how death can be related to a wide range of different concepts, such as vitality, renewal, fertility, childbirth, and the completion of space-time cycles remain unanswered.

Current research involves the use of interdisciplinary approaches to the study of the region. One illustration of this is the study of iconography as a historical source of information, rather than as merely aesthetic. Detailed iconography and elaborate grave goods are excellent examples that summarized the cooperative arrangements that the living organized to introduce their dead into the netherworld and into the afterlife, by recreating a natural world in the hereafter. Curiously, there seems to be a tendency to find that the items related to death are more elaborated than the artifacts used in everyday life and/or domestic activities, which suggest the ambiance of pre-Columbian

cultures and invites us to explore the myths behind the motifs.

Mónica J. Giedelmann Reyes

See also American Indian Beliefs and Traditions; Day of the Dead; Death, Anthropological Perspectives; Death Superstitions; Depictions of Death in Art Form; Depictions of Death in Sculpture and Architecture; Embalming

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Middle Age and Death

To understand the relationship between middle age and death, these concepts must be situated in their cultural and historical context. In the case of people in the United States who are currently middle age, their historical beginnings are located between the late 1940s and the early 1960s, in that demographic cohort whose ideas, assumptions, values, and styles defined the era that became known as the baby boomers. At each stage of their lives, the baby boomers redefined the character of that age-specific category, from childhood through youth, until their current position, middle age, poised on the verge of what was previously referred to as old age, but now cast in a more flattering light as seniors or golden-agers.

The social scientific literature on middle age and death is fragmented, made up of the literature on the definition of middle age and the literature on the specific character of their death experiences, such as the care of elderly parents in decline, a task that makes it difficult for baby boomers to sustain the fanciful belief that came out of the 1960s that they would never age and never die. The purpose of this entry is to explain the attitudes of middle-aged people in the United States toward death, the particular character of their perceptions of death, and to point out the ways in which these attitudes and confrontations are grounded in their generation experience.

History of the Baby Boom Generation

That bulge in the population pyramid that represents the baby boomers, those who were born between 1946 and 1964, during a period of prosperity, were the major factors in explaining why the United States became youth centered. Their numbers and their spending power constituted a powerful force in the economic marketplace. They were listened to and courted as no previous generation of young people in the United States had been before. Their popular culture styles were imitated by both the younger and the older generations. They were led to believe that they were wiser and morally purer than their parents and grandparents, who, in a rapidly changing society, had nothing to teach them. One of their slogans, "Don't trust anyone over twenty-five," became "Don't trust anyone over thirty," and then disappeared. The new age category that Bennett Berger termed "almost endless adolescence" evolved in a youth-centered society into a middle age with an ever-expanding outer limit.

The cultural center of gravity during the 1960s became young people, with children at one end and middle-aged adults and the elderly at the other, tending to emulate youthful styles. As the baby boomers aged, they carried the importance of their style along with them. So, for example, jeans came to be worn by all age groups, and casual dress for one day a week even spread into corporate settings.

The baby boomers are beginning to reach retirement and are on the verge of old age. This is occurring during a period during which the United States has shifted to a less obvious death-denying society but one that is nonetheless obsessed with aging and its inevitable outcome, death. The images of old age are changing from white-haired men and women sitting in rockers smoking pipes or knitting to physically fit and smiling late-middle-agers on water skis or tennis courts. Euphemisms such as "seniors" are invented, and cosmetic surgery is used to mask the advancing years. The solution baby boomers have found for the depredations of old age is to never grow old.

Middle Age

The definition of middle age varies. The U.S. Census Bureau defines middle age as 35 to 65. A study of workers in a Middle Eastern country defined middle age as ranging from ages 30 to 59. Such variations, although modest, reflect the fact that life stages in the United States may no longer be clearly defined. The less-than-clear line of demarcation between age groups may be due to a combination of at least two factors: the contemporary United States has more life stage transition categories than any society in history, and the United States became a youth-centered society.

The variability in defining middle age is paralleled by vagueness in the behavioral expectations attached to each of these age-graded social roles. Neal Postman has pointed out that the age specificity of clothing styles is rapidly disappearing, as is the meaning of childhood as understood until the post–World War II period. His phrase, the "disappearance of childhood" is symbolized by the fact that boys on the verge of adolescence sometimes wear suits to birthday parties and men in their 60s sometimes wear jeans. The notion that you are only as old as you feel is now operationalized as you are only as old as you look to others.

The fuzziness of the borders of ages has a particularly powerful effect on the middle age, caught as they are between a socially valued youth and what appears to be a socially disvalued old age. Perhaps this is why the middle age gave birth to the midlife crisis, whereas no crises are attached to any other age category.

Death and Middle Age

Middle-aged people confront death in a number of forms common to all ages. The death of friends, pets, and siblings affect middle-aged people, but no distinctive patterns explainable by age exist. However, some forms—the death of contemporaries, anxiety about death, the death of parents, and suicide—take particular shapes for the middle age.

Death Rates and Death Anxiety

Dividing middle age into the three specific deciles used by the U.S. Census for the ages 35 to 65, the death rate in the last third, 55 to 64 is more than four times that of the first one-third, 35 to 44. Although their coming of age coincided with the Vietnam War, a disproportionate number of deaths in that war were from the lower end of the stratification system.

As more of the age cohort members of the oldest third of the middle-aged population begin to die off with some notable increase, and people nearing the end of middle age (55–64) experience the deaths of their parents, death anxiety or fear of death declines through middle age and into old age. The fact that, to a great extent, the culture of the United States is still death denying, and also the fact that a sense of invincibility is carried over from adolescence into adulthood offer a partial explanation for this apparent insulation from death anxiety.

The Trials and Death Experiences of the "Sandwich Generation"

Middle-aged people often find themselves caring for children under 18 and for parents over 65 while also handling the obligations of their careers. Caught between the dependence of two generations, the middle-aged group is often described as the "sandwich generation." By the third decade of middle age, virtually all of their children have passed the age of 18, with the majority attending college.

After age 65 and when the overall health of the parents of the middle-aged group generally declines, their parents' dependence generally increases, and the death of their parents becomes an even more likely event. Perhaps the decline in death anxiety is

also explicable in part because of the middle-aged group's witnessing the oftentimes extended decline of their parents, followed by their isolation in institutions, which encourages the anticipatory grief that many experience.

Middle Age and Suicide

In the three decades that constitute the government's statistical definition of middle age, the suicide rate rises, peaks, then falls, and continues to fall in the 65 to 74 decile, and ultimately peaks again for all age groups over 75. The most consistent increase from 1995 to 2005 was in the 45 to 54 decile.

Although there is no agreement among suicidologists on the reasons for this increase, it is useful for understanding this increase to place the 45 to 54 age group on a timeline in relation to careers, marriage or the failure to marry, and to their generation experiences, such as changes in the economy. In trying to explain the increase in youth suicide, the sociologist Menno Boldt suggested that instead of focusing only on possible increases in the pressures on young people, the possibility that there may be less resistance among the young to committing suicide may also be operating. That is, research supports the contention that suicide may be a more acceptable option for the young.

The combination of increased pressure and diminished resistance may be true for the middle age as well. Economic vicissitudes may cause career changes to become more common in that age group with retirement a long way off, and, as traditional marriages become less common among their role models, the young, social pressures may reach critical mass in middle age. With euthanasia now tied to the idea of a dignified death, and with the cultural emphasis on the importance of the individual, one effect of which is the de-emphasis of the importance of the community, and, as a consequence, the weakening of ties to the community, the ability to weather adversities may be attenuated. Suicide may seem a less onerous alternative, particularly as suicides in their own age group become more common. In sum, less resistance to suicide rather than increased pressures pushing people over the edge may apply as well to that second third of the middle-aged population as it does to the young.

In conclusion, death intrudes on the lives of the middle-aged people in many forms. They experience the deaths of contemporaries, particularly in the last third of middle age. There is a rise in the suicides of contemporaries. They experience the deaths of their parents. Placing the current generation of middle-aged people in historical perspective, they were the baby boomers who were treated as the "chosen" generation to whom things like death, or anything untoward, shouldn't happen.

In addition to being caught between dependent children and dependent parents, this particular generation of middle-aged Americans represents the so-called sandwich generation in two other senses. First they are caught between the social value of youth and the stigma of old age. In addition, the middle age is psychologically equidistant between Sir Thomas Browne's dictum that "The long habit of living indisposeth us for dying" and the practical sense of Julian Huxley, H. G. Wells, and G. P. Wells's perceptive observation in their book, *The Science of Life,* that the young desire personal immortality, not the old. As they grow older, their view may shift to this latter wisdom. On the other hand, perhaps as they have done so many times before, the baby boomers will prove their chroniclers wrong.

Jack Kamerman

See also Adulthood and Death; Death Anxiety; Friends, Impact of Death of; Life Cycle and Death; Widows and Widowers

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Military Executions

This entry focuses on the who, offenses, place, number, how, and by whom of U.S. military executions. These are deaths that have been imposed on U.S. military personnel because of misconduct and behavior in violation of military codes of conduct. In most instances, the executions resulted from unanimous jury decisions that were reviewed and approved by military judges. Nearly all of the information is from the American Revolution, the American Civil War, World War I, and World War II—no U.S. soldiers were executed during the Korean or Vietnam Wars.

Historical Background of Military Executions

Lower Ranks

Those executed from the American Revolutionary War through World Wars I and II came primarily from the lower ranks of volunteers and draftees of noncommissioned personnel. There is one notable exception. A 1919 dispatch from Dijon, France, reported that the American army authorities at Is-sur-Tille hanged an American Lieutenant for an assault on a little girl.

Because the U.S. military was segregated until 1948, race illuminates much about who was executed during the 20th century. During WWII, nearly 80% of the 70 soldiers executed in the European Theater of Operations were black, even though they comprised approximately 10% of the troops. The exact racial distribution of the 35 American WWI executions between April 6, 1917 and June 30, 1919, is unknown. However, 25 of these executions took place within the United States, and 17 involved black soldiers. Thirteen of the 17 were executed in August 1917, for participating in a riot in Houston, Texas. During the next year (1918) 3 more black soldiers were hanged for assaulting a 17-year-old white girl. Eleven more soldiers were executed during WWI in France, 8 (73%) of whom were black.

Type of Offenses

Throughout our history, soldiers have been executed for crimes specific to the military, (e.g., desertion, mutiny, and/or cowardice). They have also been executed for misbehavior defined as felonies by civilian authorities that are also prohibited by military law—murder, rape, and murder and rape together. During the American Revolutionary War, General George Washington approved hundreds of executions, some for desertion. On April 23, 1779, two soldiers were shot at Washington's Morristown, New Jersey, camp for repeated desertion. During the American Civil War, more than 275 men were executed for military offenses by the Union Army, whether guilty or not. More than half of these deaths resulted from desertion; some of the others included cowardice. No soldier was executed for desertion again until WWII. During WWI, no soldier was executed for a purely military offense, leading one army colonel to conclude that this was evidence of the good conduct and discipline of the American soldiers who served abroad. The U.S. Army has executed no soldier since 1961, when a black trooper was hanged for raping an 11-year-old white girl in Austria.

During war and peace, U.S. military executions have almost invariably been held at military installations. General Washington's executions are thought to have occurred outdoors on parade grounds at military camps or forts. The same practice appears to have been followed by the Union Army. The major purpose of these executions was discipline by example.

The place of death for each of the 35 WWI executions is unknown, but at least 17 of the U.S. deaths were outdoors, within the confines of a military camp before several, if not all, of the soldiers stationed thereby. An exception to this practice took place in Gievres, France, when a white soldier's execution for murder took place in secrecy to avoid causing a disturbance in a nearby camp.

During WWII, 18 American soldiers were executed in England for offenses committed in Ireland, England, and Wales. Except for two soldiers who were shot, each of these men were hanged. WWII executions in France occurred at one of two places—either inside a military prison if the victim was a member of the military or semipublicly at or near the scene of the crime if the victim was a civilian, depending on the conditions of war.

Selection Processes

With few exceptions, U.S. military executions have resulted from trials instead of command-ordered

field executions, mass executions, or lotteries. One notable exception occurred during the Civil War. Confederate partisan leader, John Singleton Mosby, used a lottery to select 7 out of 27 Union soldiers to be executed without trial. His action was in retaliation for a similar execution of seven members of his command by members of the Union Army.

To date, army executions in American history have relied on hanging and shooting—the needle has yet to be utilized. Hanging has traditionally been considered the more ignominious method because its death causes greater suffering and is less instantaneous than shooting. During the Civil War, the Union Army used both methods of death almost equally for murder and rape. Soldiers convicted of desertion, pillaging, spying, and mutiny were almost always shot. Of the approximate 1,112 soldiers executed for desertion from the Union Army, 100 (89%) were shot.

During WWI, the U.S. Army continued to use the rope for nonmilitary offenses—each of its 11 executions were accomplished by hanging. This method was used predominately throughout WWII. Only 6 of the 70 soldiers executed in the European Theater of Operations were shot. Desertion during WWII, although potentially a death offense, was always punished with imprisonment or dismissal, with one famous exception—Private Eddie D. Slovik, a white soldier who was killed before a firing squad.

No more than 17 American sailors and marines have been executed since 1849—significantly less numerous that army executions. But there was another capital shipboard crime. Sodomy, though not a capital offense today, prior to 1861, was a death crime in the British Royal Navy. No American soldier has been executed for sodomy, but many have been court-martialed and dismissed for this behavior. Shipboard executions of sailors and marines have always involved hanging, with one notable exception. In Richard I's 1190 C.E. ordinance of six offenses to which the crusaders would be subject, two carried punishment by death. When someone slayed a man on shipboard, they were bound to the dead man and thrown into the sea. If the killing occurred on land, the offender would be bound to the dead man and buried in the earth.

During and after the Revolutionary War, soldiers have been put to death by U.S. military personnel with two well-documented exceptions. Before the U.S. Army developed its own hangmen in WWII's European Theater of Operations (ETO), it relied upon the professional skills of two of England's Home Office official civilian hangmen, Thomas and Albert Pierrepoint. Firing squads, though relatively rare, comprised noncommissioned enlisted men commanded by an officer. Hangmen, by comparison, were with some regularity prison commandants with officer rank. The interment of the 70 soldiers executed in the ETO and the combined 26 put to death in the North African Theater of Operations (NATO) and Mediterranean Theater of Operations (MTO) illustrate that ignominious deaths suggest ignominious burials. The 18 American soldiers executed in the Shepton Mallet prison in Bath, England, were at first interred in unconsecrated land located "backstage" on the outside perimeter and adjacent to toolsheds and a compost heap in the large Brookwood Cemetery, London. Those executed in France, Algeria, and Italy were also initially buried in graves separated from those who had died honorably.

At war's end, most of these executed soldiers were exhumed and reinterred in a walled-off, secret section of the World War I Oise-Anise American Cemetery, Fere-en Tadenonis, France. A few, approximately five, were sent home to their next of kin. The executed deserter, Eddie Slovak, was returned in 1987. The final place of burial for all of the other executed U.S. soldiers during WWII include 20 at the Post Cemeteries at Clark Air Force Base, Luzon, Philippine Islands, 25 at various Post Cemeteries within the United States, and 5 at the Schofield Barracks, Hawaii. Six executed soldiers are buried in private cemeteries in the United States.

The U.S. Army executed relatively few of its soldiers in the last century compared to Great Britain and France. During WWI alone, France executed approximately 600 soldiers, most for mutiny and desertion. Britain put to death 350 during WWI. The U.S. Army has carried out at least 459 executions since the last navy execution in 1849. In the 20th century, the U.S. military terminated approximately 160 of its soldiers—none by summary execution, though rumors and allegations claimed otherwise and resulted in official investigations.

Future of Military Executions

One of the more striking features of first-world nations in the Western world during the last 100 years

has been the abandonment of the power to execute citizens. This raises interesting and perplexing questions about the future of intra- and inter- as opposed to extra-military executions. Put simply, will militaries continue to execute their own members? At issue is whether the time-honed argument that the military is a unique institution whose emphasis on efficiency through discipline requires the availability of executions as an essential element of social control, especially during war. Clearly the mounting evidence suggests the contrary.

Because inter- and intramilitary executions are extremely rare, it is difficult for its proponents to point to the use of executions as an efficient tool for discipline and deterrence. Of the 266,785 British soldiers convicted of military offenses during WWI, for example, only 2,675 were sentenced to death and only about 10% of this number were actually executed. The United States has not executed a soldier for a military offense in nearly 60 years. Great Britain, too, has not executed a solider since before WWII.

Furthermore, there is no empirical evidence that there is any difference in the efficiency or effectiveness of fighting armies because of the use of the military executions. During WWI, the Australian armed forces fought bravely and effectively, and did so without having the burden of high-level formal discipline and without a deterrent death sentence for misconduct such as desertion.

Abandoning Military Executions

There is little doubt that the world has learned more about military executions during the 20th century than at any other time. The reasons for this historical point are that its wars, especially World Wars I and II, are relatively recent, well documented, often controversial, and interesting enough to a number of broad audiences to encourage ongoing amateur and professional research. One important contribution to the military execution knowledge base in recent years has been the addition of Internet websites that are devoted to military executions and civilian capital punishments. Despite their popularity, many of these websites contain incomplete and/or misleading information. But the popularity and current interest in military executions is expanding, in part because with the benefit of hindsight and close examination, past executions are increasingly understood as an integral part of the great human tragedy—war.

J. Robert Lilly

See also Burial at Sea; Causes of Death, Historical Perspectives; Prison Deaths; Social Functions of Death, Cross-Cultural Perspectives; War Deaths

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Miscarriage and Stillbirth

Pregnancy loss is a surprisingly common occurrence, but often goes unrecognized, unregistered, or unacknowledged. Medically, fetal death represents a challenge to the worldwide goal of reducing child mortality. Psychosocially, the death of a child before birth, because it represents neither the entry of a new person into society nor the departure of a recognized member of the social order, presents unique challenges to the grieving parents.

Definitions

Miscarriage, or spontaneous abortion, is defined by the World Health Organization (WHO) as a fetal

death in early pregnancy. Stillbirth is defined as the death of a fetus late in pregnancy, during the perinatal period, from 22 weeks gestational age through 7 days postpartum. Individual countries rather arbitrarily define the gestational age at which a pregnancy termination is classified as either a miscarriage, early stillbirth (typically 20–28 weeks gestation), or late stillbirth (after 28 weeks). Some industrialized countries classify death at 16 weeks gestation as a stillbirth. If the gestational age is unknown, a birth weight of 500 grams is often used to make the distinction between miscarriage and stillbirth. Stillbirths are also often classified as antepartum (before the onset of labor) or intrapartum (during labor). This variation in the classification of miscarriage or stillbirth makes epidemiological monitoring and intervention difficult.

Rates

About 15% to 20% of pregnancies result in miscarriage, the most common complication of early pregnancy. The rate is much higher if one includes pregnancies that end within six weeks of the last menstrual period, often before a woman is aware of the pregnancy. Eighty percent of miscarriages occur within the first trimester.

Approximately 5% of first pregnancies end in miscarriage. Most women who miscarry go on to have successful pregnancies, but about 1% of women have recurrent (more than three) miscarriages. The risk of subsequent miscarriage or stillbirth increases with each prior stillbirth or complicated pregnancy. The rates of twin and multiple births have increased in the past two decades, associated with growing use of assisted reproductive technologies. The risk of stillbirth is four times greater in multiple pregnancies than in pregnancies with just one fetus.

The WHO notes a worldwide incidence of stillbirth at 3.9 million, with about 26% of those stillbirths occurring during the delivery of a mature fetus. These figures are generally thought to be underestimates because most births in developing countries occur in the home and information is not reported. The rate of stillbirth in developing nations is 10 times greater than in the United States. The most recent figures reported by the WHO estimates the stillbirth rate in the United States as 3/1,000, on a par with the figures reported for Canada, Australia, and much of Europe.

Causes

Miscarriages may be the result of chromosomal abnormalities, progesterone deficiencies, uterine malformations or infections, or uncontrolled diabetes. However, most causes of miscarriage are unknown and thought to be unpreventable.

It is difficult to obtain data on the causes of stillbirth because of a lack of uniformity in protocols for classification of stillbirth and the declining rates of autopsies. Where protocols are available, it is found that the most common causes of stillbirth between 24 and 27 weeks' gestational age are infection, placental problems, or fetal malformations. Between 25% and 60% of stillbirths are due to unknown causes. Death during labor is rare in the developed world, but in developing countries as many as 1 in 100 babies die during delivery. It is presumed that access to good obstetric care could prevent these deaths, as well as late stillbirths due to maternal/fetal infection.

In the United States, the most prevalent risk factors for miscarriage and stillbirth are first pregnancy at a young age, advanced maternal age, obesity, and high blood pressure. Access to prenatal care decreases the risk of fetal death, and in the United States, social and demographic factors associated with limited health care availability (poverty, minority status, rural residency) are important risk factors. African Americans have a higher risk of stillbirths. Other risk factors include smoking, and alcohol or cocaine use during pregnancy.

Physical recovery following miscarriage or stillbirth is often relatively uncomplicated. However, psychological recovery is far more complex. There has been little or no research on the psychological impact of miscarriage and stillbirth on the mother in developing countries, where stillbirth and miscarriage are common pregnancy outcomes. In the United States, most cultural groups highly value children, and the death of a child is considered a profound tragedy and an occasion for mourning. The death of a child before it is born, however, presents a unique bereavement situation.

Grieving Pregnancy Loss

The birth of a child is a highly anticipated event. Almost from the moment of conception, parents-to-be form idealized expectations of what their child will be like. With the routine use of ultrasound

imaging, the fetus becomes real to the parents, and a parental bond is formed long before the actual birth. In the event of a miscarriage or stillbirth, parents are mourning at a birth. Despite reassurance that the miscarriage or stillbirth was unpreventable, the mother often blames herself for her body's failure to carry a child to term.

The course of grief following stillbirth and miscarriage is variable. Anxiety and depression are common in the first few months after the loss, but some people experience little distress even as soon as two months postloss. Most symptoms of anxiety and depression dissipate over time, but some parents remain distressed for years following the loss. Within a couple, it is most common for one partner, not both, to be distressed.

An interesting paradox is that while friends and relatives celebrate pregnancy and eagerly anticipate birth, a pregnancy loss is barely acknowledged. There is a strong cultural taboo in America against recognizing the psychological significance of miscarriage and stillbirth. In the climate of silence surrounding pregnancy loss, funeral rituals following miscarriage are not common, and cultural practices may prohibit ritual burial of a preterm infant. On the other hand, significant changes to hospital protocol following a stillbirth promote memorialization. It is now routine hospital psychosocial practice to offer the parents photos of their stillborn child and tangible mementos, such as locks of hair, footprints, ID bracelets, blankets, and so forth. Parents treasure these objects as tangible representations of a real baby that died and as a continuing bond with their dead infant. In addition to offering mementos, many hospital bereavement teams encourage parents to see, hold, and interact with their stillborn infant. A recent series of studies suggests that this latter practice may be associated with heightened anxiety and depression during a subsequent pregnancy and with disordered behavior in the subsequent baby.

As with most unanticipated traumatic events, a crisis of meaning is created. Memory is often disrupted, and there is a need to tell and retell the story of the loss of the pregnancy until it makes sense. Parents must create a new life narrative, different than the one they had expected. Pregnancy loss social support groups have been developed in recent decades to provide a safe forum where grieving parents can shape their stories and remember and memorialize their dead babies. These support groups rely heavily on the use of shared rituals and written expression to alleviate the commonly voiced fear that the parents will forget their baby. More recently, the Internet has provided a virtual forum for memory and shared support through pregnancy loss websites.

While many expectant mothers who experience stillbirth and miscarriage are greatly distressed at the loss and at their body's inability to successfully complete a pregnancy, most are determined to try again. Fortunately, most women who miscarry go on to have healthy babies. While medical advice is that it is safe to conceive shortly following miscarriage, psychologically it is more complex and there is no one right answer. There is likely to be heightened anxiety during a subsequent pregnancy.

Helping After Pregnancy Loss

There is no one right way to grieve. Hospital personnel should be aware that cultural norms regarding bereavement and emotional expression differ, and they should be sensitive to the variety of initial reactions to the loss. While nurses might gently offer the parents the opportunity to hold their baby if they wish, this option should never be forced upon parents. In general, hospital personnel, friends, and family should respect and honor parents' individual wishes and cultural practices, acknowledge the depth of the loss, and be available to listen with sensitivity and compassion, and without judgment, as parents reshape the narrative of their lives.

Bronna D. Romanoff and Lisa M. Farley

See also Grief, Bereavement, and Mourning in Cross Cultural Perspective; Grief and Bereavement Counseling; Infant Mortality; Neonatal Deaths

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Missing in Action (MIA)

MIA is the abbreviation for missing in action and is used to describe a member of the armed forces who has been reported missing after combat operations. The service member may be injured, captured, or even dead, but his or her status is unknown. The term MIA was originally coined in the United States, and it is still used primarily by Americans. However, this abbreviation was not used until 1946 (just after the end of WWII). Those designated as MIAs must not have been accounted for in any way, that is, they must not be reported as killed in action (KIA) or captured as a prisoner of war (POW).

In many ways, the status of MIA, because of its ambiguity, is known to be more devastating to family members and friends than KIA. At least when people are confirmed dead in combat operations, there is a sense of closure that does not exist for those left to wonder about the fate of their loved ones.

Incidence

Although the term MIA did not come into existence until 1946, the U.S. Armed Forces have always had members with MIA status in all armed conflicts. For example, it is estimated that American MIAs from the Revolutionary War numbered about 1,426; from the War of 1812 about 695; from WWI some 4,452; from WWII 78,773; from the Korean War approximately 8,100; and from the Vietnam War 1,763. In the Iraq War, or Global War on Terror (GWOT), two members of the United States military are MIA. In the GWOT, there are also American civilian MIAs based on their work on behalf of civilian nonprofit groups, civilian contractors, and reporters working with the military in Iraq and Afghanistan. The reduced number of MIAs in America's more recent conflicts (Vietnam and the GWOT) is due to better evacuation of troops immediately following combat operations. Thus, fewer personnel were ever left behind after a battle and even the seriously wounded can be carried off with their comrades. Although there were relatively few MIAs in Vietnam, the term MIA became most prominent after this war in Southeast Asia.

The Politics of MIA

The term MIA began to take on a political meaning after the Vietnam War. The war had been politicized in the late 1960s and into 1970 to 1972. In the United States, people became more polarized over the issue of Vietnam and eventually, the majority of Americans wanted the U.S. military out of this conflict.

When the Paris Peace Accords were signed between the United States and North Vietnam in 1972, the North Vietnamese stated that they still held 591 POWs, many of whom had been listed as MIAs. Within a few months, all 591 were repatriated to the United States. Yet, many Americans believe that many more MIAs were held by North Vietnam in hopes of negotiating for financial settlements from the United States. It is also believed by many that the remains of other MIAs were also held back by the Vietnamese government again in hopes of ransom. There are those who believe that through the 1970s, 1980s, and even into the 2000s, some former American MIAs were and are still alive in Vietnam.

Identifying MIA Remains

In 1973, soon after the Paris Peace Accord was set in place, the U.S. Department of Defense

established the Central Identification Laboratory in Thailand to serve as a coordination center for POW/MIA recovery efforts throughout Southeast Asia. It was hoped that this would serve as a center for information on MIAs. By 1976, another Central Identification Laboratory was established in Hawaii to aid in searching for and identifying remains of MIAs from previous wars. A Joint Task Force Accounting Project was then established to achieve a full accounting of Americans missing from the Vietnam War. In 2002, the U.S. Department of Defense determined that the two identification laboratories should be combined with the Joint Task Force. By 2003, the Joint POW/MIA Accounting Command (JPAC) was established under the Commander of the United States' Pacific Command. JPAC utilizes 18 recovery teams that travel around the world in an attempt to recover MIAs or their remains from past wars.

MIA and Social Activism

The determined effort to find MIAs, especially from Vietnam and the rest of Southeast Asia, is the result of the effort of many groups throughout the United States that have taken up the cause of Vietnam-era MIAs. The largest of these is the National League of Families of American Prisoners and Missing in Southeast Asia. This group was established in the 1960s and incorporated in the nation's capital, Washington, D.C., in 1970. Its emblem, a black flag with the white silhouette of a man next to a guard tower, is well known throughout the United States. Above the silhouette are the words "POW*MIA" and underneath the words, "You are not forgotten." This flag is flown outside a number of American homes and at major U.S. institutions on the public holidays of Veterans Day and Memorial Day. This league has also distributed hundreds of thousands of identification bracelets each inscribed with the name of a Vietnam-era MIA. The mission of the league is to secure the release of all prisoners of war, to account for the missing, and to return the remains of American decedents of the Vietnam War.

Another large nonprofit agency dedicated to POWs and MIAs is Rolling Thunder, Inc. Its members include many motorcycle riders who have staged rallies in Washington, D.C., each Memorial Day weekend since 1987. The mission of Rolling Thunder is raising the public's awareness of American soldiers who are prisoners of war or are missing in action. On Memorial Day 2007, the 20th such Rolling Thunder rally, hundreds of thousands arrived in Washington, D.C., under the banner "We will never forget."

MIA Records

The Library of Congress maintains a database of some 147,000 records pertaining to missing Americans from Southeast Asia. Much of what is contained in this database are records of the U.S. Senate Select Committee on POW/MIA Affairs. This committee was established in October 1991. According to the Library of Congress, the committee's tasks included, among others:

- To determine whether there was evidence that there were other MIAs from Vietnam who had not been returned by Vietnam and to determine if there was evidence that some may have been alive in captivity.
- To ensure the adequacy of government procedures for following up live-sighting reports and other POW/MIA related information.
- To demystify the POW/MIA accounting process so that the families and the public can better understand the meaning behind the numbers and statistics used in discussions of the issue.

The committee's final report found that there was no credible evidence that any POW/MIAs from Southeast Asia were still alive in that region of the world. This information was not welcome news to many families of MIAs, as they had clung to hope that their loved ones were still alive.

MIA-Related Research

A great deal of research was carried out with families of MIAs from the Vietnam War to discover how the wives and children were coping with the task of continuing on while uncertain as to whether their husbands or fathers were still alive (all the Vietnam era POW/MIAs were men). The families of MIAs live in a state of chronic stress because there is no closure with respect to their husband or father. Such families have been

described as experiencing "unresolved bereavement" and "prolonged ambiguous grieving." They do not have a clear understanding of their loss as one would after the death of a loved one. This ambiguous loss has many negative effects on the wives and children of MIAs. There is discussion of the difference between the physical presence of a husband or father and his psychological presence. The families of MIAs have only the symbolic presence of the husband or father figure; his physical presence is no longer real and yet there is often hope of his return.

In interviews carried out about two years after the husband or father had been declared MIA, mothers reported that about 20% of their children had behavioral problems, such as frequent crying, nightmares, acting out, shyness, and fear of the dark. Fewer than half of these children received any professional help. Those children who had actual memories of their missing father had the most severe problems. Even in studies 20 years after the MIA status of the father, some of the now adult children of MIAs still had problems with intimate relationships. There were several common themes played out in the lives of these adults whose fathers had been declared missing in action while they were children. These themes include fear of abandonment, feelings of depression, lack of trust in others, feelings of anger, and a fatalistic attitude toward life.

The one fact that stood out in all of this research is that the mothers' adjustment was the major predictor of children's psychological well-being. Mothers who carried out the roles that their husbands would have played (in addition to their own) had the children with the fewest problems. Mothers who went on with their lives: going out of the home to work, continuing on with interrupted education, and recognizing that the husband/father might not return, and that the family had to cope without him, were the best adjusted, as were their children. The mothers who kept the psychological or symbolic presence of the husband/father in the forefront of family life were the least well adjusted, as were their children. In spite of the fact that these "coping" mothers had their own unresolved grief, they tried to make the lives of their children as normal as possible. Mothers who had remarried had adult children with the fewest problems. The Department of Defense (DoD) now provides training for all military and civilian members of the DoD in personnel recovery. This training alerts their members to the difficulties of those who are "isolated, missing, detained or captured" after combat operations. So it now may be true that "we will never forget."

Kathleen Campbell

See also Ambiguous Loss and Unresolved Grief; Funerals, Military; Memorials, War; Tomb of the Unknowns; War Deaths

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Monuments

Monuments commemorate a person or an event in history. In relation to death, monuments are built in tribute to the dead, in honor of victims of war and accidents, or as efforts to immortalize someone's deeds and ideas. Monuments are an attempt to rescue a person, group, or event from anonymity, and they help keep survivor's memory alive. The idea of perpetuity is supported by the materials that are often used for monuments—bronze, granite, marble, iron—that withstand the ravage of time, but monuments can also be made out of less permanent materials, such as wood, or made out of living materials. Monuments connect the present with the past. They evoke personal memories, but equally important, they help groups to remember their past.

Growth of a Commemorative Culture

The erection of monuments for commemorative purposes is found in all historical periods. For instance, the pyramids of ancient Egypt are mausoleums built for the enduring commemoration of the deceased. Another example is the roadside grave or memorial that marks travel-related death and which is an act of commemoration that dates back to ancient times. Prehistoric traders of amber, flint, and freestone in central Europe often buried their dead alongside the road. In ancient Rome, mausoleums were built at the street side where the fatal accident occurred. The increasing number of monuments in Europe and the United States, however, and the urge to record events of death at its contemporary rate is a rather new phenomenon. The start of a commemorative culture is hard to fix, but World War I, with its industrial mechanization of death, was one of the first instigators to a collective need to remember. Wars in 20th century reach farther—geographically and socially—than that of earlier, nonindustrial conflicts.

In addition to the two World Wars, the interest for the past and the recollection of memory extended under the influence of several factors. First, the fast modernization after World War II that resulted in the decline of traditional life forms led to a nostalgic longing for a lost world. Second, the increased prosperity and the growing leisure time stimulated the emergence of a commemorative culture. Third, European unification and the process of globalization that leads to an increased interest in a nation's past and the affirmation of national identities also fuels commemorative culture. The search for and affirmation of social and political identity follow important breaks in history, like the French Revolution of World War II. Another reinforcement of the flowing number of monuments we find in the study of roadside memorials in which the construction of monuments is seen as a response to sudden and tragic death in a society where death has been removed from everyday life.

The Range of Monuments

A distinction can be made between the creation of a spontaneous memorial and the construction of an official monument. Memorials are often constructed immediately after death occurs and are an expression of grief over the death of particular people. For instance, immediately after the death of Princess Diana in 1997, the public left thousands of flowers and other tributes outside the gates of Kensington Palace. These spontaneous acts of commemoration are often followed up with official monuments constructed by an artist at the initiative of survivors and authorities. Several monuments were constructed over the years for Princess Diana. One of them is the Diana, Princess of Wales Memorial Fountain in Hyde Park, London, which aims to reflect Diana's life and symbolizes her qualities. The function of a monument extends beyond the expression of grief; they become reflections of someone's life, bearers of national histories, communicators of political messages, and places of collective memory.

Another distinction can be made between individual monuments and collective monuments. Examples of individual monuments are tombstones, mausoleums, or statues picturing a famous figure. Individual monuments, however, can become part of a collective need to remember. For example, the grave of Jim Morrison in the Paris graveyard Père-Lachaise, and the burial plots of national heroes, musicians, and writers all have become places of worship. Collective monuments memorialize a connected group of deceased (e.g., war victims and veterans) or an event that caused

many deaths (e.g., an airplane crash and September 11, 2001). Although these monuments have a collective purpose, the loss of individuals can be remembered through the victims' names, which are written on monuments.

Monuments tell the story of a deadly event or the person that died, unveiling the cause and circumstances of death. This story is often literally and symbolically translated in the design of the monument, texts written on plaques, and monument location. The United Flight 93 Memorial Sculpture and Garden in Shanksville, Pennsylvania, is an illustrative example. On September 11, 2001, when United Flight 93 crashed, students from a nearby school and the small community of Shanksville supported the rescue workers in many ways; they bottled water, prepared sandwiches, and offered shelter. In the recollection of this event, the helping hands of the community emerged as a powerful image of what happened. The artist, who was commissioned to create a monument in honor of the victims, the students, and the community, took her inspirations from this image. The sculpture appears as a form rising from the ground with pods that bear many hand imprints. The sculpture is located in a garden adorned with nine large stones, bearing quotations from famous Americans, which inspire patriotism, courage, and self-sacrifice that were evident this September day.

Collective Memory and Identity

Monuments serve the individual memory and grief of the people who are directly involved: survivors, witnesses, and the bereaved. Collective expressions of loss help individual bereaved accept the fact of death. More important, monuments as anchors of memory have a collective and public function. Through the monument, memory is extended in time and range beyond the memory of the people who are directly involved. Monuments are often built on a location of historical or symbolic interest, frequently marking the place where death occurred. Being landscape markers, monuments are part of the *lieux de mémoire*—sites of memory—of a group of people or a nation. Monuments form the boundary stones of another age according to historian Pierra Nora, who introduced the concept of places of memory. Lieux de mémoire are places where people can identify with their past. Along with museums, archives, cemeteries, festivals, anniversaries, and sanctuaries, monuments serve the construction of a cultural memory.

The cultural memory of a nation determines the collective and individual remembrance of a society's culture and is the basis on which national identity is constructed.

Nora argues that lieux de mémoire originate with the sense that there is no spontaneous memory; memory is a social and cultural construction. A cultural memory cannot embrace all individual memories, and its construction is always a selecting and generalizing process. There will always be groups whose stories are excluded from the dominant discourse. Elite groups and political authority have a powerful hand in the construction of a cultural memory. They use public space, of which monuments are part, to communicate to the public a particular kind of national or cultural consciousness. For this purpose, public monuments are the most conservative of commemorative forms, precisely because they appear unchangeable and are meant to last forever. Portraying only selective parts of a nation's history, monuments determine the way people remember and how they shape their national identity.

Monuments embody a multitude of memories, emotions, and messages. They can tell a message of honor, respect, complaint, sacrifice, hope, and protest at the same time. The construction of memory through monuments and the attachment of meaning to monuments are not univocal. The past, rather than be preserved as some objective record, is always being constructed and reformulated in the context of the present. Contesting perspectives on the monument are of different natures, about the esthetical judgment or the emotional or political value. Many monuments, however, do generate shared or widely held interpretations. They not only project the intended meanings of their constructors, but the interpretation of them by its visitors is facilitated by dominant ideologies in society.

Monuments, being focal points for memory, are often the locus of rituals. They are sites where commemorations are performed and collective memory is reinforced. Liberation days, for instance, are celebrated at the national war monument. The repetition of these national and collective rituals at a particular monument emphasizes the importance

of this site as lieux de mémoire. Moreover, visits to war monuments such as the Vietnam Veterans Memorial and the Cimetière du Père-Lachaise in Paris are popular. The nature of these visits ranges from tourism to pilgrimage. Monuments induce emotions and expressions of grief and remembrance in the form of letters, flowers, and candles can be found near roadside monuments, on graves, or at the foot of a famous statue. The performance of commemorative rituals near monuments articulates and reformulates the meanings that are inscribed in the monument. Collective memory is constructed and reinforced in these performances.

Remembrance induced by monuments is not only aimed at the recollection of the past and the reinforcement of memory. Mainly when they are associated with war, violence, and accidents, they are increasingly connected with a concern for the present and the future by way of asserting the hope and making the promise "this may never happen again."

Transformations of Monuments

Although a monument seems to be static and permanent, the meanings attached to it and even its outlook can transform over time. The adding of new plaques and new monuments to older ones give insight into a power struggle that takes place at some monuments, for example, the struggle of relatives for rehabilitation of British World War I soldiers who were shot for cowardice. These soldiers, traumatized by the experiences of war, tried to escape their war duties, resulting in their execution. It was more than 90 years after World War I that these soldiers were publicly acknowledged as war victims. By that time some of their names were finally included in the long lists of names on World War I monuments. Another illustrative example is the construction and reconstruction of the Vietnam Veterans Memorial. The initial design was that of two black granite memorial walls on which the name of the 58,000 men and women who died in service were written. It lacked any reference to patriotism and national symbols. Later on, the American flag, a heroic statue picturing three soldiers, and the inscription "God Bless America" were added to the walls in order to meet the wishes of the public. The contrast between expressions of patriotism, on one hand, and on the other hand, personal grief, is still vivid and visible at this monument.

Societal developments and changing perspectives on the past and present are reflected in commemorative acts and reconstruction of monuments. New wars are commemorated and new war victims are honored at liberation days. In other occasions, monuments fall into disrepair over the years as soon as their significance passes into oblivion and their function decreases. The cultural memory of a nation is nonstatic and nonpermanent and transforms along with the monuments.

Monuments are material things: seemingly static, unchangeable structures in the public space that are intended to last forever. However, they are dynamic, and it is their ability to communicate a multitude of messages that determines their importance in public space. They evoke specific kinds of emotions and meanings, and they serve as spatial coordinates for individual and collective memory.

Janneke Peelen

See also Memorials; Memorials, Roadside; Memorials, War; Tombs and Mausoleums; Tombstones

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Mortality Rates, Global

There are major differences today in the mortality rates of the countries of the world. Babies born in Japan or Sweden live much longer than those born in Botswana or in Lesotho Southern Africa. Why do these differences in life expectancy exist among countries? Levels of development, medical conditions, and a host of other factors are involved.

The major causes of death are not the same in countries with high and low levels of life expectancy. There have been changes over time in the major causes of death. People used to die mainly of infectious and parasitic diseases, but the major causes of death today in developed countries such as the United States are heart disease and cancer. In this entry, we discuss these and related issues.

Historical Evidence

Our knowledge of mortality levels and conditions prior to the Industrial Revolution is incomplete. We know that mortality was high then, but the availability and completeness of the death data leave a lot to be desired. According to Scheidel, age data from census records of Roman Egypt indicate an average life expectancy at birth in the 1st to 3rd centuries C.E. of between 22 and 25 years, a finding corroborated by data on tombstones in Roman North Africa. As late as the 18th century, life expectancy ranged from only 30 to 40 years in much of Europe and the United States. Males in the United States in 1901 had a life expectation at birth of 47.9 years, and females, 50.7 years.

Causes of Death

The eminent demographer Donald Bogue has noted that death is caused by a number of reasons and diseases, which require the understanding of the etiological factors of the major causes of death. Data on the causes of death, even today, are far from complete. Some deaths around the world are not even registered. In many countries, a large proportion of deaths occur outside the presence of a physician, and the cause is either unknown or incorrectly diagnosed. Often the cause of death is misrepresented or camouflaged if it is socially unacceptable, such as suicide, syphilis, or HIV/AIDS.

Moreover, international comparisons of cause-of-death data are difficult because countries often differ in terminology, method of certification, diagnostic techniques, and the quality of the coding and data collection system. Nevertheless, some generalizations are possible about the general structure of cause of death in the contemporary world.

Death is a complex behavior, and there are literally many thousands of ways to die. But some causes of death occur more frequently than others. For instance, the World Health Organization reports that in 2002 there were approximately 57 million deaths in the world. The top cause of death throughout the world was cardiovascular disease; coronary heart disease accounted for 7.2 million deaths, and cerebrovascular disease and stroke accounted for another 5.5 million deaths.

People around the world, however, do not all die of the same major causes. There are differences, and these are largely due to the socioeconomic levels of the countries. The World Health Organization has developed an illustrative example. Consider a hypothetical population of 1,000 people to represent all the women, men, and children around the world who died in 2002. Of these 1,000 decedents, 138 of them will have come from rich countries, 362 from middle-income countries, and 501 from poor countries. For each group of countries, the distributions of deaths are not identical, nor are they ranked in the same way.

Concerning the 138 people from the rich countries, coronary heart disease is the cause of 24 of the deaths, 13 will die from stroke, and 8 from lung cancer. HIV/AIDS is not one of the major causes of death in this group of countries. Less than 15% of the population of the world lives in these countries, and they account for only 7% of all the deaths.

In the middle-income countries, nearly one-half of the people live to age 70, and the major causes of death are the chronic diseases, just as in the rich countries. The difference, however, is the role of HIV/AIDS as a major cause. Of the 362 deaths to people from the middle-income countries, 54 will have died from stroke or other cerebrovascular diseases, and 49 from coronary heart disease. Twelve people will have died from lower respiratory infection and 12 more from HIV/AIDS.

In the poor countries (many located in sub-Saharan Africa), less than a quarter of the population

attains the age of 70, and nearly a third of all deaths are to children under the age of 14. Of the 501 people from these countries dying in 2002, 54 will have died from coronary heart disease, and 50 from a lower respiratory infection. HIV/AIDS will be responsible for the deaths of 38 people. Thirty-two infants will have died from perinatal conditions. Thirty people will have died of stroke or other cerebrovascular diseases.

Life Expectancy

We have noted considerable variation around the world in causes of death. Life expectancy also varies considerably. According to data of the Population Reference Bureau, in 2007, a baby born in Japan, on average, could expect to live for about 82 years; a baby born in Sweden, about 81 years; and a baby born in the United States, about 78 years. In contrast, a baby born in 2007 in Botswana and Lesotho, Southern Africa, could expect to live on average 34 and 36 years, respectively.

In the world in 2007, life expectation at birth was about 68 years (66 years for males and 70 years for females). These are averages, but for the most part, the higher the country's level of economic development, the higher its life expectancy for both males and females. In the countries of the less-developed world in 2007 (accounting for 5.3 billion of the world's 6.6 billion people), life expectancy at birth was 66 years (64 for males, 67 for females); if we exclude China (an economically less-developed country, but demographically developed with low fertility and high life expectancy), life expectancy is 64 years (62 for males and 65 for females). Compare these figures with those for the more developed countries of the world, with an overall life expectation at birth of 77 years (73 for males, 80 for females).

Changes in Life Expectancy

The United Nations in its *World Population Prospects* notes that the 20th century was the era characterized by the most rapid decline in mortality in human history. In the early 1950s, life expectation in the world was 46 years, and, as we just noted, it is now 68 years. The United Nations projects that over the next 45 years, life expectation for the world will reach 75 years. Life expectancy in the developed world is projected to increase from its 77 years in 2007 to 82 years by mid-century and 74 years for the less-developed countries.

The increases in life expectancy expected for the more-developed and the less-developed countries tend to hide the variation in these changes among the world's major areas. The trends illustrate that, on average, the countries of Asia, Latin America, the Caribbean, North America, and Oceania have been experiencing increases in life expectancy at a steady pace. Europe, however, shows a slowdown beginning in the late 1960s through the late 1980s. According to the United Nations, this is due to a decrease in life expectancy in Eastern Europe, mainly the Russian federation and the Ukraine. Other countries in Europe have among the highest life expectancies of the world. Unlike the situation in the other regions of the world, increases in life expectation since the late 1980s in Africa have been stagnant. According to the United Nations, this is due largely to the HIV/AIDS epidemic, as well as armed conflict, economic problems, and the prevalence of infectious diseases, such as tuberculosis and malaria. These trends have halted progress in life expectancy by reducing it by approximately 15 years. In the years 2005 to 2010, Africa is expected to have levels first seen there in 1990 to 1995. In 2045 to 2050, life expectancy is expected to increase to 66, but this is still 12 years below the 2007 life expectancy in the United States.

HIV/AIDS

HIV/AIDS is a major worldwide pandemic that is ravaging the world. As of the writing of this entry, the world is more than 25 years into the HIV/AIDS epidemic. Acquired Immune Deficiency Syndrome (AIDS) was first noticed in the United States in 1981. Hemophiliac cases of AIDS were first reported in 1982. The human immunodeficiency virus (HIV) causing AIDS was isolated in 1983 at the Pasteur Institute in Paris. By the late 1980s and into the 1990s, HIV/AIDS had been identified in every region of the world. HIV is spread person to person via contact with body fluids. Zaba notes that this disease can spread through sexual intercourse, blood transfusions,

from mother to child in the course of the pregnancy, delivery, or breast feeding, and even through use of unsterilized hypodermic needles and surgical instruments.

According to the United Nations Joint Program on HIV/AIDS, as of 2006 around 65 million people worldwide have been infected since the virus was first recognized in 1981, and over 25 million have died. Two-thirds of all people living with HIV in 2006 were in sub-Saharan Africa, where HIV is mainly transmitted via heterosexual sex. Although sub-Saharan Africa is by far the most affected region in the world, epidemics are also underway in Central Asia and Eastern Europe, where in 2005 an estimated 220,000 people were newly infected. It is clear that the HIV/AIDS epidemic has had, and continues to have, an impact on the populations of many countries of the world. An estimated 25 million people have already died of AIDS, and around 40 million people are now living with HIV.

The United Nations reports that HIV prevalence is estimated to be at least 1% among the population aged 15 to 49 years in the 58 most highly affected countries of the world. Four very large countries with HIV prevalence rates below 1%, namely, Brazil, China, India, and the United States, need also to be considered in this discussion because of their large absolute numbers of persons currently living with HIV, increasing the above total to 62 countries. Of these countries, 40 are located in sub-Saharan Africa, 11 are in Latin America, and 5 are in Asia. As a combined group, they include over 35 million of the around 40 million adults and children in the world who are infected with HIV, or approximately 90% of the total number of people living with HIV in the world. Eight countries, all in Africa, have astoundingly high HIV prevalence rates. Swaziland has 33.8% of its population aged 15 to 49 infected with HIV, followed by Botswana at 24.4%, Lesotho at 23.1%, Zimbabwe at 20%, Namibia at 19.7%, South Africa at 18%, Mozambique at 16.3%, and Zambia at 16.9%. Outside of Africa, no other country has an HIV prevalence rate higher than Haiti's of 3.8%.

While the spread of HIV/AIDS has played a major role in the life expectancy of some countries around the world, the trends and causes of death are likely to differ as medical progress is made and the political and economic circumstances of countries change.

Dudley L. Poston Jr. and Eugenia Conde

See also Accidental Death; Causes of Death, Contemporary; Causes of Death, Historical Perspectives; HIV/AIDS; Life Expectancy; Mortality Rates, U.S.

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Mortality Rates, U.S.

Mortality rate (also referred to as the death or fatality rate) is used to describe the ratio of total deaths to the total population in a particular community over an established period of time. It is often expressed as the number of deaths per 100,000 of the population in a given year. When thinking specifically about U.S. mortality rates across time, dramatic changes have occurred over the past 300 years. U.S. mortality rates during the colonial period are considerably different than those that characterize present-day society. Mortality rates within a given year also vary

significantly due to specific characteristics that include demographic, economic, geographic, sociocultural, and political factors. Differences based on age, gender, race and ethnicity, income, education, and occupation all serve to influence U.S. mortality rates. This entry explores U.S. mortality rates across time, and it details group-specific differences in mortality rates at certain periods.

U.S. Mortality Rates: 1600s Through 1800

Prior to 1800, there is limited information available on U.S. mortality rates; information about mortality rates during this period is often pieced together from a range of sources that include newspaper articles, government documents, speeches, public records, individual letters, and diaries. When the U.S. Census first started recording data in 1790, deaths and causes of death had not been uniformly recorded.

The early colonial period is generally characterized by a young population profile and high rates of death, affecting the young and old alike. Harsh conditions paired with the contamination of food and water, high risk of intestinal worms and infection, along with infectious disease had deleterious effects for many. Epidemics involving infectious diseases, including smallpox, measles, mumps, malaria, dysentery, scarlet fever, venereal diseases, typhus, bubonic plague, and yellow fever, are documented throughout the 17th and 18th centuries. U.S. death rates attributed to epidemics were significant during this period. For example, the smallpox epidemic, which hit Massachusetts in 1677, killed hundreds, or around 12% of the state's population.

Native Americans suffered greatly from European colonization in terms of mortality rates, with the combined deleterious effect from infectious disease, as the result of war, slavery, and genocide. And, while there is little data on African American mortality rates during the colonial period, it is widely thought that mortality rates across the life course, from infancy through adulthood, were as much as four times higher in the African American community. A wide range of factors explain these higher mortality rates, including lack of access to adequate medical care, nutrition, and shelter, paired with widespread mistreatment.

U.S. Mortality Rates: 1800s

Information on U.S. mortality rates during the 19th century is typically derived from census data. Mortality statistics based on death registrations were first published in 1850. These data are incomplete because the information was not uniformly recorded in all U.S. jurisdictions. Further insights into late-19th-century mortality rates are provided by morbidity reports on contagious diseases authorized by the U.S. Congress.

Notable changes in science, medicine, technology, and the practice of public health practices during the 19th century inspired shifts in U.S. mortality rates. While traditional religious explanations for disease, sickness, and death were in the past commonplace, this perspective was increasingly eclipsed by scientific discourse aimed at identifying and ameliorating illness, and ultimately, death. During the mid-19th century, the fields of bacteriology and microbiology gained significant knowledge, and the germ theory of disease served to link certain diseases to specific pathogens. With research from scientists like Great Britain's Edward Jenner and the French-born Louis Pasteur, vaccines were developed (based on the experimentation with disease-preventing inoculation that first occurred in China and India more than 2,000 years ago) to help prevent a number of devastating diseases, including smallpox. By the mid-1880s, the cholera organism was identified and contained. General anesthetics were also introduced during this period, which further enabled life-saving surgical interventions, as antimicrobial substances were applied to the body to reduce the possibility of lethal infection.

Despite these scientific developments, however, infectious diseases continued to serve as major health threats and were responsible for the majority of deaths throughout the 19th century. Poor sanitation, overcrowding, and unhealthy housing situations in growing U.S. urban areas are attributed to many epidemics that spread across the country during this time.

U.S. Mortality Rates: The 20th Century

The first annual report on mortality available in the United States began in 1900, with data provided by 10 states, the District of Columbia, and a number of additional urban areas. With the addition of

Texas in 1933, information on mortality rates for all of the United States was accessible.

When comparing a population across time, it is common to look at the death rates of specific age groups. Infant mortality rates, for example, are regarded as a measure of a community's overall well-being, and during the 20th century, Centers for Disease Control and Prevention (CDC) data reveal that infant mortality in the United States was reduced by about 90%. Age-adjusted mortality rates are also used to standardize the effects age has on mortality; age-adjusted rates reveal what the level of mortality would be if yearly changes in age composition of the entire population did not occur. As depicted in Figure 1, the age-adjusted mortality rates across all age groups declined significantly during the 20th century.

The age-adjusted death rate in 2000 fell to 872.4 deaths, compared with 1,446 deaths in 1950, and 2,518 deaths in 1900. The decline in age-adjusted U.S. mortality rates, based on data from the National Center for Health Statistics (NCHS), reveals life expectancy at birth in 1900 was 47.3 years; by 2005, life expectancy had increased to 77.8 years of age.

Reasons for Declines in U.S. Mortality Rates

The decline in U.S. mortality rates during the first half of the 20th century is largely attributed to declines in infectious disease. Public health efforts and medical advances, including vaccines and antibiotics, helped reduce the infectious disease rate. In 1917, vaccines for cholera and typhoid were introduced, followed by additional life-saving vaccines protecting against diphtheria, tetanus, tuberculosis, yellow fever, polio, measles, and influenza.

Improvements in water quality in U.S. cities between 1900 and 1940 also had significant favorable effects on reducing U.S. mortality rates. Chlorination and water filtration in U.S. cities helped to instigate a decline in death rates in urban areas during this period. Clean water had an even larger impact when considering infant and child mortality rates in the United States during the first half of the 20th century. Antibiotics, or antimicrobial agents that deter disease-causing bacteria, also had an impact on mortality rates at this time, with penicillin, discovered in 1928, credited as the first effective antibiotic.

Mid-Century Shift From Infectious to Chronic Disease

By the mid-20th century, a dramatic shift in causes of mortality was underway as a rise in chronic diseases associated with an aging population became dominant. NCHS data reveal that the five leading causes of death in 1900 include

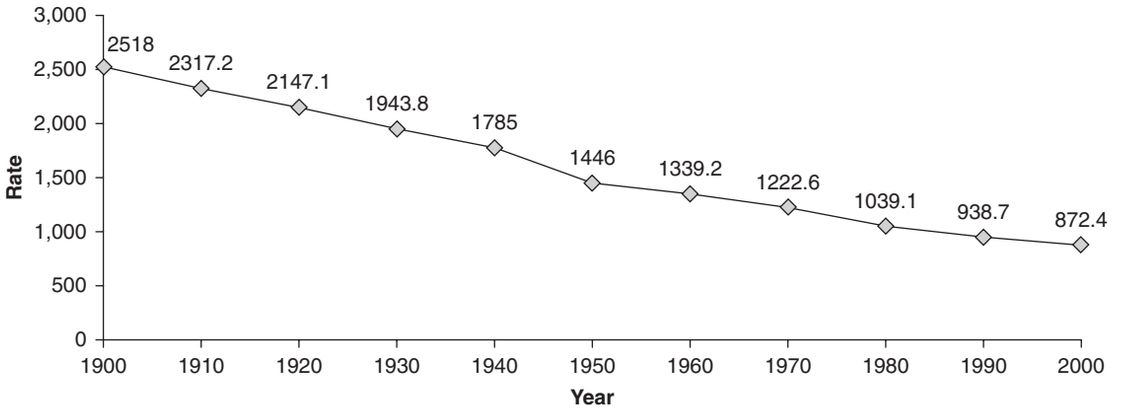

Figure 1 Age-Adjusted Death Rates for the U.S. Population, 1900–2000

Source: Adapted from data in "Age-adjusted Death Rates: Trend Data Based on the Year 2000 Standard Population" by D. L. Hoyert & R. N. Anderson, September 21, 2001, *National Vital Statistics Report*, *49*(9). Retrieved September 8, 2008, from http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_09.pdf

Note: Age-adjusted death rates are used in order to eliminate differences caused by differences in overall population age. The above death rates are based on Year 2000 population distribution estimates.

influenza/pneumonia, tuberculosis, diarrhea, heart disease, and stroke, a significant change compared with 2005 when heart disease, cancer, cerebrovascular diseases, lower respiratory diseases, and accidents are the leading causes of death (see Figures 2 and 3).

While mid-20th century data appear to be similar to the present, some differences are notable. Tuberculosis was the seventh leading cause of death in 1950; it is no longer in the top 10 in 2005. In contrast, Alzheimer's disease is the sixth leading cause of death in 2005. Age-adjusted death rates

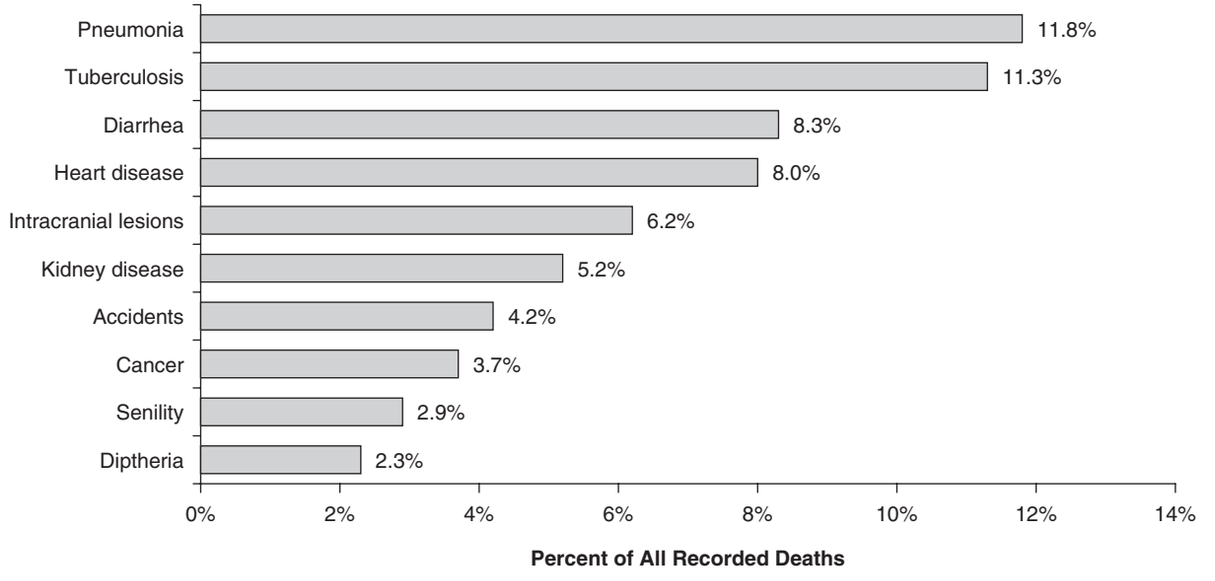

Figure 2 Top 10 Causes of Death, U.S., 1900

Source: Adapted from data from "Leading Causes of Death: Death Registration States, 1900" by the National Office of Vital Statistics, 1947. Retrieved September 3, 2008, from http://www.cdc.gov/nchs/data/dvs/lead1900_98.pdf

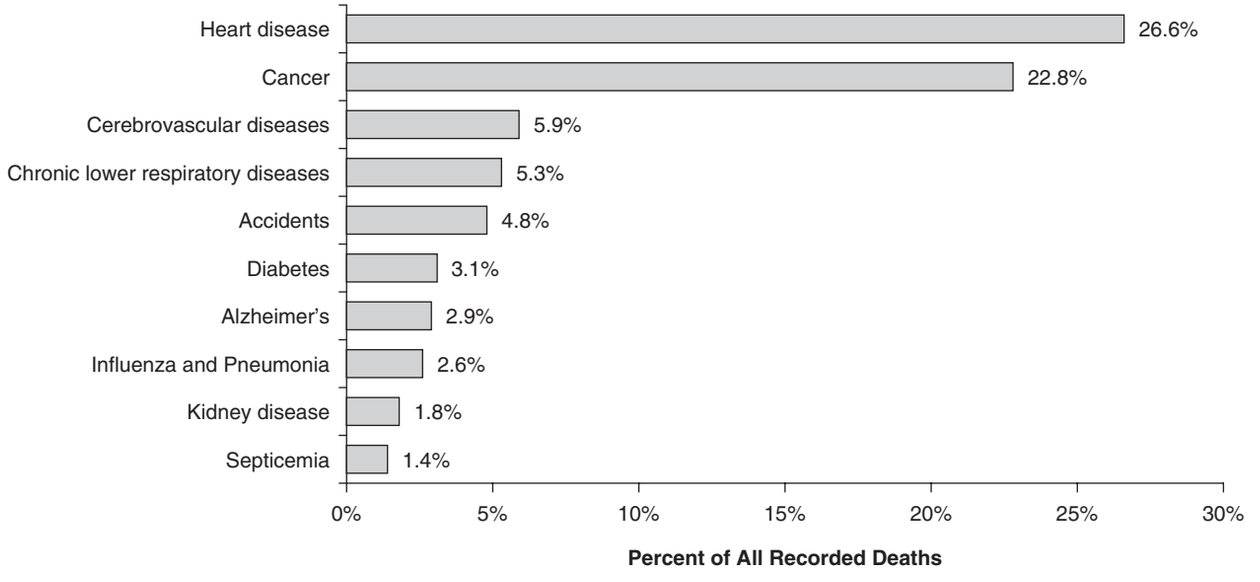

Figure 3 Top 10 Causes of Death, U.S., 2005

Source: Adapted from data in "Deaths: Final Data for 2005" by H.-C. Kung, D. L. Hoyert, J. Xu, & S. L. Murphy, April 24, 2008, *National Vital Statistics Report, 56*(10), p. 5. Retrieved September 3, 2008, from http://www.cdc.gov/nchs/FASTATS/lcod.htm

reveal that mortality due to heart disease and cancer has declined. Lifestyle factors have received increasing public attention as public health campaigns focus on exercise, diet, alcohol consumption, smoking, sleep, obesity rates, and stress levels as targets to improve health and decrease mortality.

While the 20th-century improvements in age-adjusted mortality rates are noteworthy, significant variations remain. Exposure to environmental factors, such as pollution and temperature extremes, are implicated in higher death rates. Further, improvement in health status and declines in mortality rates have not been evenly realized across all sectors of the U.S. population; notable gaps based on age, race, ethnicity, socioeconomic status, and gender remain.

Factors Influencing Mortality Rates

Socioeconomic Status

Mortality rates are often linked to socioeconomic status as people with higher levels of income, education, and occupational status have a greater life expectancy. Cross-national research reveals that the highest average life expectancy is found in countries where income variations between poor and rich are the smallest; health inequalities that intersect with mortality rates are thought to stem from what has been called the amount of relative deprivation in each country.

Sex Differences

Sex differences in U.S. mortality rates have long been documented. Explanations include exposure and response to stress, changes in health care, and lifestyle factors. While male mortality rates have typically been higher than female rates through the 20th century, during earlier times, the risks associated with pregnancy and labor made women during their childbearing years particularly vulnerable. Differences in mortality between men and women remain; one such difference lies in the gender gap in life expectancy, which in 2005 was 5.2 years.

Racial/Ethnic Differences

Differences in U.S. race and ethnic mortality rates have been particularly persistent over time. Comparing the African American population to Caucasians in 2005, life expectancy for the Caucasian population was 5.1 years longer. These same differences are noted for maternal and infant mortality rates. The maternal mortality rate for the African American population in the United States is 3.3 times greater, and the infant mortality rate is 2.4 times greater. The overall maternal mortality rate in 2005 was approximately 15.1 deaths per 100,000 live births, with the rate for African American women at 36.5 deaths per 100,000 live births, compared with 11.1 deaths for Caucasian women.

Conclusion

During colonial times and through the end of the 19th century, U.S. mortality rates were largely linked to major health threats involving infectious disease often associated with poor hygiene, sanitation, nutrition, weakened maternal or infant health, and physical injury. Chronic diseases like heart disease and cancer have played a much larger role in U.S. mortality rates from the mid-20th century through the present.

There remains ample opportunities for improvements in U.S. mortality rates. The future of U.S. mortality rates is contested, as many scientists believe that the declines realized over the 20th century will slow due to biological limits. Yet others suggest that scientific breakthroughs may lead to future reductions. Census Bureau projections suggest that U.S. life expectancy at birth will continue to increase with the most optimistic estimates predicting life expectancy in 2100 to be about 94 years.

Diane M. Watts-Roy

See also Acute and Chronic Diseases; Causes of Death, Contemporary; Causes of Death, Historical Perspectives; Gender and Death; Infant Mortality

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Mortuary Rites

Rites or rituals as described by some authors are common features in all human societies. They consist of gestures and words dedicated to an object, such as a person, group of people, an occasion, or a material thing, of which the sacred character is acknowledged in a given human community. This kind of behavior should be distinguished from mere perfunctory conduct, as prescribed by codes, for instance. Rituals are met at all levels of the social order, within small arenas as well as society at large. For most sociologists and anthropologists, the function of rituals is to secure a certain mastery of temporality: The same gestures, words, or songs give the impression that time always goes through the same common places. This is the collective way of responding to the need for "ontological security," as defined by Anthony Giddens.

The occasion of death is of course one of the main anchorages of ritual behavior, be it for an individual, a small collection of people, or a vast gathering of people. This behavior is related to two outstanding social duties toward both the deceased and the bereaved. There is first the duty of saying farewell to the dead, and second, the duty of welcoming the dead in the realm of the dead. In a much-celebrated work, Arnold van Gennep sketched the general outlines of all "rites of passage," valid in principle for all kinds of human societies. Resorting to various stage sequences, the aim is to bestow upon an individual or sometimes a collection of individuals a new identity leading to a new condition. This is true of all the great events in one's life, like birth, initiation, marriage, enthronement, and death. Those rites follow a tripartite pattern: A first sequence underlines the separation of the individual from his or her group of belonging; a second one aims at placing him or her at the margin, figuring in this manner his or her transitory status; and a final one integrates the individual into a new status. Of course, this pattern is subject to many variations according to the huge display of cultural contexts within the human order of things.

In a seminal chapter of his famous book *The Elementary Forms of the Religious Life,* Emile Durkheim makes use of the words "piaculary rites," indicating that the origin of these rites lies in the idea of expiation. But the meaning of the term is broader: "Any misfortune, anything that is of bad omen, anything inspiring feelings of anguish or of dread calls necessarily for a *piaculum,* and, by consequence, is called *piacular.*" Therefore, bereavement represents one example of piacular rites. Durkheim then distinguishes between rites of pure abstention and rites of ceremony, the first pertaining to his notion of negative cult and the second, positive cult. Abstention, for example, means it is forbidden to mention the dead person's name, to stay at the place where the death occurred, or to deal with foreigners. The reason for such prohibitions lies in the sacred character of the dead, that is, his or her body. All that is or has been related to it finds itself, by contagion, in a religious state that excludes any contact with the things of the secular realm.

The positive cult rendered to the dead schematically follows a three-stage pattern (in the actual or virtual presence of the corpse), possibly completed by a fourth stage, sometimes long after the funeral. These three stages are (1) a farewell of the living to the dead, (2) the translation of the corpse from the realm of the living to that of the dead, (3) the reception of the dead person in the realm of the dead followed by the disposal of the corpse, according to the cultural habits of a

particular community. Often these rites begin with the moment that the death seems imminent. All stages include prayers and tears, sometimes also dances and songs, or at least some kind of music. Speeches are also held, often in praise of the deceased. Praising, even by concealing possible misdeeds, is the rule, and the fact is that most of the members of the audience are not duped.

The Three or Four Stages of Mortuary Rites

The first stage, following van Gennep's pattern, is that of the farewell to the deceased by the realm of the living. The assembly announces to the dead person that he or she is no longer a member of the community: Most of the time, the announcement is made by a prominent or specialized member of the assembly. In religious settings, this duty rests upon the shoulders of a member of the clergy. The ceremony over which he or she presides has a liturgical character. Even when it takes place within a secular environment, as with cremation in the absence of a churchman, it tends to inspire religious pageantry. In the Catholic world, the ceremony used to be the occasion of playing a *Requiem*. The deceased is called to rest eternally in the church's womb. It can be said that this stage is generally the most dramatic of all that take place in the presence of the dead body.

The possible fourth stage, that of the commemoration, may sometimes bear the same dramatic character, especially when the deceased has not been allowed to leave the community with enough dignity. Then the act of commemoration is akin to one of repentance, or at least of rehabilitation.

Usually, the rites of translation are to be seen in the habit of funeral corteges, which in ancient times displayed many mourners and much public grief. Sometimes this grief was feigned by people paid for the occasion, hired from the poorer part of the population. In some countries, weeping female mourners would also be hired, and they would let loose their tears at every stage of the ritual process. In the contemporary experience, the motorized hearse drives at normal traffic speed from the funeral parlor, the hospital morgue, or, more rarely, the home of the deceased to the church, or directly to the cemetery or the crematorium, followed by a small number of cars. There is practically no sign of mourning. The presence of wreaths on the hearse is the sole token of the "last journey" of a previous member of the living society.

The next stage is that of the welcoming into the realm of the dead. This may take place at the side of the newly dug grave, in the form of prayers and/or a brief speech by the officiating minister. The same can be said of cremation ceremonies. But in some societies, much rejoicing may occur, taking the form of festive meals and other kinds of celebration. Animal or even human victims are sometimes slain on the grave or on the pyre. In India, the widowed wife would self-immolate on the burning body of her late husband. All these rites have the same meaning (i.e., of emphasizing the definitive departure of the dead and the starting point of the bereavement period for the survivors). The latter are often compelled to wear clothes or other signs indicating their state of mourning. In modern Western society, these signs have nearly, or sometimes completely, disappeared.

It may happen that the treatment of the corpse is delayed with regard to the welcoming ceremony, which may also include farewell words or gestures. The scattering of the ashes, for instance, may take place after a certain lapse of time after the cremation itself. Or the actual burial may be postponed with regard to the farewell ceremony, and be held in an exclusively private way. In traditional Jewish culture, a special ceremony, that of the inauguration of the grave (i.e., the placing of the gravestone) takes place at the first anniversary of the death.

Durkheim has rightly stated that what lies at the origin of the mourning behavior is "the impression of weakening which is experienced by the group when losing one of its members. But this impression in itself results in bringing closer the individual members, connecting them more narrowly, and associating them in the same soul spirit, from which emerges a feeling of comfort compensating for the initial weakening." Grief behaviors are supposed to reaffirm the existence and the cohesion of the group, in some cases of the whole community, when one of its prominent members has passed away, or when a highly symbolic death has occurred (e.g., that of a child or a victim of a horrendous crime). In many cases, these behaviors are to be performed for a longer time within the directly related group of the dead, such as relatives and close friends, than within the society at large.

Wearing mourning clothes, weeping at any evocation of the dead, abstaining from washing oneself, or fasting, are typical forms of behavior, but many other forms are found all over the world. Also ranked among the piaculary rituals are the habits of inserting obituaries in the newspapers, placating them in public venues, the sending of letters of condolences, and also the holding of religious services at regular intervals after the deceased's departure.

Commemorations and Remembrances

Commemorating means reviving the memory of some important event. Examples are numerous at the collective level: birth of a Nation (4th of July), death of the Ancient Regime (14th of July), and explosion of a revolution (7th of November), and so forth. Some of these collective revivals deal with death, be it that of a lone individual (Gandhi or Martin Luther King) or that of a huge number of individuals, such as at war (Armistice Day as celebrated at the Cenotaph in London on the nearest Sunday to November 11). With the popularizing of the "duty of memory," commemoration ceremonies have become rather common. Commemorating may also be staged at the individual or group level. The occasion may be that of celebrating a joyous event, as in the case of the silver, ruby, golden, or diamond wedding anniversary.

Commemorating one's death is in some contexts mandatory, in others not. The celebrating acts may be private, such as bringing flowers to someone's grave by way of a birthday present. The ritualistic dimension then becomes discreet and may even be unnoticeable: Saying a silent prayer on some occasions in honor of a deceased close relation is a kind of rite that remains secret, but its function is that of all rites, controlling the passing of time and seeing to it that oblivion does not occur.

Mortuary rituals seemed to be on the wane during the last few decades, but one can detect a kind of reversal of this trend, especially in cremation ceremonies. We can thoroughly get rid of someone's corpse, but never get rid of death itself. And trying to cope with it by resorting to rites remains one of the most imperious concerns of humankind, at all levels of collective existence.

Claude Javeau

See also Bereavement, Grief, and Mourning; Eulogy; Funerals and Funeralization in Cross-Cultural Perspective; Lamentations; Wakes and Visitation

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Mortuary Science Education

Mortuary science education is designed to train individuals to become funeral directors and embalmers and assist them to meet state-imposed licensing requirements. Postsecondary mortuary science programs are most prominent in the United States and Canada. This is due, in part, to the high rates of embalming in these two countries, combined with governmental licensing requirements for funeral practitioners. Internationally, most training of funeral workers is done through apprenticeships. Japan, for instance, which adopted a national examination for funeral workers in the 1990s, has only two schools with programs in funeral direction. In the United Kingdom, formalized mortuary science education programs were instituted in 2008 (at the University of Chester and the University of Bath). In Australia, there are no educational requirements for funeral workers, though there are six programs that award nationally recognized certificates. Similarly, New Zealand has one university that offers two separate degrees for funeral work but does not require its funeral workers to hold a degree.

Although most countries lack formal education requirements for funeral workers, many national trade associations are attempting to introduce legislation to mandate educational prerequisites in

their respective countries. The International Federation of Thanatologists Associations (IFTA), founded in 1970 and headquartered in Monaco and the Netherlands, includes Canada and the United States as members. One of the objectives of the IFTA is to advocate for global educational and regulatory standards for funeral workers that are uniformly administered.

Most funeral workers in the United States and Canada are required by law to be licensed to practice their trades. However, only some funeral workers are required to have formal education, a requirement that varies from state to state or province to province. In the United States, where workers must have at least some postsecondary education, the American Board of Funeral Service Education (ABFSE) is responsible for overseeing mortuary science and funeral directing education programs. The International Conference of Funeral Service Examining Boards (ICFSEB) oversees the tests that are administered to students wishing to become licensed practitioners, and a liaison works between the ABFSE and the ICFSEB to ensure continuity of criteria.

While the licensing of funeral directors is overseen by individual states in the United States, all people who desire to obtain a license must pass a national examination administered by the ICFSEB. Approximately half of all the United States and some Canadian provinces have a dual licensure program. In states and provinces that maintain two separate licenses, funeral direction and embalming are considered separate and distinct. Thus, there are different sets of requirements for obtaining each license. Almost all states and provinces, regardless of the licensure system, require some formal secondary education in order to be a licensed embalmer (often a 2-year associate degree). In places with dual licensures, funeral direction typically does not necessitate earning a college degree but an apprenticeship that, while varying in length, is generally one to two years.

Since 1970, the number of mortuary programs in the United States has increased from 21 programs to 56 accredited programs in 2005. There are currently 10 such programs in Canada, according to the Funeral Service Association of Canada. Slightly less than one-half of the U.S. schools make available some form of distance learning in their curricula. Most of these mortuary science programs are a part of 2-year, degree-granting institutions, but there are 4-year baccalaureate mortuary science programs in the United States. Some mortuary science programs offer additional certificates for those wanting to become pathology assistants and/or forensic investigators.

In 2008, members of the ABFSE narrowly voted against accrediting mortuary school programs that would allow students to earn a degree in funeral direction that excludes courses in embalming. The push for a degree in funeral direction only has been a recurring issue because of the funeral industry's trend toward the differentiation of occupational roles (i.e., workers specialize in embalming, sales, or funeral arrangements rather than all three).

History of Mortuary Science Education

Embalming, the central task around which mortuary education has evolved, is an ages-old practice that extends back at least to the ancient Egyptians. However, embalming in North America was most often used for the preservation of cadavers for the purposes of medical research. Prior to the American Civil War and for some time after, most Americans buried their dead close to home, either in church graveyards or in family burial grounds. Relatives and neighbors of the deceased took responsibility for cleaning and burying the body. The war dead often had to be transported hundreds of miles to their burial ground, creating a need to preserve the dead long enough to be returned home for funeralization.

Individuals known as embalming surgeons assumed responsibility for embalming thousands of the war dead, simultaneously exposing the public to a new aspect of funeralization. Additionally, following his assassination, Abraham Lincoln's body was embalmed. Tens of thousands of mourners viewed his body en route from Washington, D.C., to his resting place in Springfield, Illinois, providing further evidence for the utility of embalming.

The English translation of an 1838 text on embalming by the Frenchman Jean Gannal was another crucial turning point for embalming education. This work served as a canonical text for itinerant educators who traveled the countryside to train others in embalming techniques. It was only near the end of the 19th century when standalone mortuary colleges began to appear. The Cincinnati

College of Mortuary Science, founded in 1882, is the oldest such college in the United States.

The nascent funeral industry of the time provided two important cultural themes that continue to be evident in contemporary mortuary science education programming, namely (1) the importance of the apprentice relationship in the education of embalmers and (2) the putative association between embalming and the medical disciplines. Today, embalmers and funeral directors in almost every U.S. state and Canadian province are required to apprentice under the guidance of a licensed practitioner. Furthermore, where formal education is mandatory, coursework related to the health sciences are central.

Mortuary Science Curriculum

The curriculum of mortuary science education includes chemistry, microbiology, anatomy, and physiology, in addition to embalming and restoration. Social science classes, especially sociology and psychology, are also required in addition to more specialized courses in grief counseling. Today, curricula also include business courses, such as ethics, management, marketing, and law.

Presently, coursework in embalming and restoration remain foundational to mortuary science education. The learning of chemical and physiological components of death, as well as the tools and techniques used in embalming, are the majority of such classes. Students also learn the history of embalming, the ethical considerations involved, and the purposes behind embalming.

According to most practitioners, embalming has a threefold purpose. The first is to preserve the body by delaying decomposition and putrefaction. Students are taught about the effects of certain diseases or medications the deceased may have taken, either of which can alter the absorption of embalming fluids. Similarly, the length of time the body has been dead, the cause of death, and the physical environment in which the body had been in postmortem (and pre-embalming) affect the techniques of embalming and the selection of chemicals.

The second purpose of embalming has to do with sanitation. Embalmers legitimate their practice as a means to protect public health through the appropriate disposal of contagious tissues and the elimination of pathogens. Students receive instruction in the proper handling of bodies as well as embalming instruments. They are also instructed in the use of particular cleansers and disinfectants.

A final purpose of embalming is restoration of the body to an aesthetic and socially acceptable appearance. The need to do so seems more critical at a time when individuals experience longer lives. With the aid of ever-evolving medical technologies, people die at older ages and yet may have undergone trauma or extended periods of illness or suffering in the process. Thus, mortuary science students are educated on ways to create a visage that suggests an absence of suffering in the deceased.

This is accomplished through a variety of procedures. Dye is injected in order to provide color or, conversely, to mask discoloration of the skin caused by either illness or medication. Chemicals deodorize the body, the mouth is sutured shut, eyecaps are inserted, and specific tissues can be injected with fluids to plump them up or drained to reduce swollen appearances. Each technique is intended to provide funeral visitors with a final, pleasing image of the deceased.

Forms of Embalming

Two forms of embalming are taught: arterial and thoracic. Arterial embalming requires the use of an embalming machine to first drain the blood from the body. Next, embalming fluids are injected and the embalming machine circulates those fluids. One must learn to make an incision, raise the correct blood vessel, insert the equipment, and operate the embalming machine.

Thoracic, or abdominal embalming, involves inserting a hollow, cylindrical trocar into the stomach to aspirate the major organs of the chest and abdominal region before injecting embalming fluids into the body cavity, also with the trocar. Embalming bodies that have been previously autopsied or bodies that have missing tissues as a result of body tissue donation requires additional expertise.

Students enrolled in embalming courses are encouraged to also enroll in an internship program so that they may develop their learned skills. Some mortuary science programs also perform in-house embalmings for the surrounding community.

Restorative Arts

Mortuary science programs often distinguish between embalming and what is known as the "restorative arts." While the former involves the application and injection of chemicals for the preservation and overall appearance of bodies, restorative arts have to do with treatments and procedures to specific areas of the body. These more localized treatments are intended to address issues such as cosmetics application, the concealment of wounds, or the reconstruction of various forms of disfigurement that occurred around the time of death. Once referred to as demisurgery, the restorative arts emerged in the 1930s to repair bodies that had been heavily damaged or mutilated so that the loved ones might have an open-casket viewing and funeral service.

Typically working on dummies, students learn to fill in missing tissue and correct for disfigurements that can result from gunshot wounds, automobile accidents, or other violent bodily traumas. Students also learn about the application of cosmetics, airbrushing techniques, and the use of various tools with which to paint or spray on concealers. Students learn how to pack cavities, apply artificial facial and head hair, inject gels, as well as perform advanced stitching techniques. The molding of clays and wax-like putties to form physical features is another component in the restorative arts.

Trends in Mortuary Science Education

According to the ABFSE, the demographic makeup of students is changing. In 1971, approximately 95% were male, and men continued to make up the majority of mortuary school students to the beginning of the 2000s. By 2008, however, just over one-half of all enrollees in mortuary science programs were female. Furthermore, the average age of mortuary school students is increasing. Only one-fifth of new students are 20 years old or younger, while one-third of mortuary school students are over the age of 30. The typical student profile is changing in other ways as well. People of color also are enrolling in increasing numbers than ever before. The percentage of white students decreased from about 85% in 1971 to 63% in 2007. Black students make up about 25% of the current student population, and Hispanics enrollees make up about 8%.

George Sanders

See also Death Care Industry, Economics of; Funeral Home; Funeral Industry; Funerals

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Mummies of Ancient Egypt

The word mummy is derived from the Persian *mumeia,* referring to the bitumen material that covered the Egyptian corpse. Thousands of Egyptian mummies have been excavated, hundreds of thousands have been lost to mummy exportation and modern urban sprawl; perhaps millions more remain in the tombs and shifting sands of Egypt.

Mummies have been part of popular culture throughout the past millennium. The European mummy trade was active for centuries, and much of this interest in mummies increased as a result of Napoleon's Nile military campaign of 1799 when a French soldier found the Rosetta stone. This stone had three sections of writing, Greek and two forms of old Egyptian writing, namely demotic script and hieroglyphics. In 1823, linguist Jean-François Champollion cracked the demotic and hieroglyphic code, which was based on a language related to Coptic.

From the Middle Ages onward, Europeans were fascinated with mummies. Placed on public display throughout Europe from the 1400s through the

1700s, mummies were thought to have medicinal benefits. Thus, human bones were ground into powder intended to serve as a cure for migraines, stomach ulcers, paralysis, and poisoning. Mummies also were used by farmers as fertilizer. Artistic paint mixed with mummy powder was used to create colors thought to have a longer lasting effect. In the 1800s, in Canada, the linen used to wrap mummies was imported to make paper, but this practice ended because of the fear of disease. And, even in Egypt, mummies were burned to fuel trains. Today, Egyptian mummies remain popular attractions for a variety of venues, including horror movies and museum exhibits.

Much of what is known about ancient Egypt is centered on Egyptian beliefs of death. Within this cultural orientation it was believed that an individual continued to exist; that is, the dead would be reborn. All that they possessed and all that made them what they were in this life remained when they were reborn. Based on this belief, many ancient Egyptians spent their entire life preparing for death. Wealthy individuals also believed this transition should be celebrated.

The ancient Egyptian death ritual progressed in an orchestrated manner after death, with mourning, preparation of the corpse, interment, and rituals for the deceased that would be continued in perpetuity. Mourning the deceased lasted up to 70 days. Believed to be useful in assisting the living to cope with death, ceremonies such as the "opening of the mouth" were thought to reanimate the dead organs and senses, particularly affecting the deceased's future ability to speak. Thus, the mummy and a statue of the deceased would be touched by a priest near the mouth using tools such as an adze and a forked *pesesh-kef* knife. This allowed the corpse to speak words that would enable the individual to continue on the path to the afterlife. Families also spoke with and brought food to the corpse, while also performing rituals during the mourning period.

Believing in the afterlife, Egyptians kept the corpse intact through mummification. The pre-Dynastic Egyptians noticed dried bodies were preserved by hot, dry sand, and were not destroyed by maggots that would normally thrive on decaying tissue. During the Early Dynastic period (3150–2686 B.C.E.) attempts were made to stop the postmortem putrefaction by wrapping corpses in linen. During this period (2686–2181 B.C.E.), Egyptians practiced a technique that allowed better body preservation through the removal of the internal organs, which were then independently preserved.

Egyptians performed embalming and employed it on the wealthy and the poor. And, because all living things were believed to be reborn and this rebirth was thought to be a continuation of individual existence, animals were mummified as well. The most elaborate mummification techniques appear to have been employed during the New Kingdom dynasties (1570–1070 B.C.E.) and the final dynasties of the pharaohs. First, the brain was scrambled and extracted through the nostril by a hook that was jabbed into the cranial cavity. An incision was made on the left side of the body to remove the lungs, stomach, liver, and intestines, and each was placed in a canopic jar sealed by a figural head of one of the Four Sons of Horus, deities that guarded specific organs into the afterlife: Imseti (a human—liver), Hapi (a baboon—lungs), Qebehsenuef (a falcon—intestines), and Duamutef (a jackal—stomach). The heart muscle, believed to be the site of intelligence, was never removed. The incision would be covered with wax or an amulet bearing the eye of Horus. The body was then cleansed with palm wine and pounded spices such as myrrh. Even the eyes were removed and replaced with wax or resin, stone, or even onions. With the organs displaced, the body cavity was filled and the body was covered with a natural salt or natron and left to dry for 40 to 70 days.

Embalmers attempted to make the dried corpse look lifelike by filling parts with sawdust, plumping up the cheeks of the face and padding the genitalia. Often animal fat and plants were used to preserve and soften the body, which was also coated with beeswax and exotic resins. Linen would be used to wrap the corpse.

The wealthy would have each toe wrapped individually and may have each toe housed in a sheath of gold. A mask was then placed over the mummy's head and the mummy was ready for burial. The poor were covered in natron, and oil of cedar or other solution was injected in the anus. Once liquefied, the intestines were purged when the anus was unstopped.

The Golden Age of Egyptian archaeological discovery was the period between the two World Wars when a most dramatic archaeological find

resulted in the discovery of the undisturbed tomb of the Pharaoh Tutankhamen on November 26, 1922. Tutankhamen was a minor ruler who died at the age of 19, probably due to an accidental fracture in the leg that became gangrenous. His burial tomb with its striking gold death mask, gold and jewelry, an enormous amount of art and wooden crafts, ritual figures, funerary furniture, clothing and textiles, games, musical instruments, and chariots among many items made Tutankhamen the most famous mummy of all time.

Within physical anthropology, paleopathology was to gain much notoriety as a scientific discipline as a result of the physical examination of mummies. Three individuals began the macroscopic mummy investigation: Grafton Elliot Smith, a neuroanatomist who is alleged to have dissected 30,000 mummies without a detailed record existing; Warren Dawson, an insurance man who became a self-taught anthropologist interested in mummification; and Alfred Lucas, a chemist who focused on the natron and other substances found on and in mummies. Sir Marc Armand Ruffer (1859–1917) would take paleopathology and mummy studies to the next level, and he would start the true scientific research on mummies. Sir Ruffer believed that with every excavated mummy, the potential knowledge gained for medical science was significant, and he explored well beyond the macroscopic examination to microscopic evaluation of the mummy tissue. He figured out how to rehydrate the soft tissue of mummies and made histological slides in order to examine the tissue for diseases. Through histological analysis, Ruffer found the calcified eggs of the blood fluke *Schistosoma* in the tubules of the kidneys of mummies dating before Christ. Not only was Ruffer one of the first to use x-rays in the analysis of mummies, but he also realized the epidemiological importance of the information to be recovered from mummies. His publications on mummies included entries on malaria, congenital conditions, tuberculosis, arthritis, and atherosclerosis. An edited volume of Ruffer's work was published after his untimely death in 1917.

The scientific study of mummies slowed during the next 50 years as physical anthropologists perfected their methods of analysis and medical technology slowly became more advanced. In the 1960s, medical doctors and physical anthropologists again turned their interest to mummy studies, and that interest continues to the present. Improved radiological equipment, new medical instruments, and the use of CT scanners have brought to bear new findings without damaging the mummy by unwrapping the linen. Scans allowed scientists to determine that the brain was removed, resin material and packing material was placed in the body cavities, and that a corpse might have congenital skeletal abnormalities, familial skeletal and dental traits, pathology, or inflicted trauma. CT scans have been pieced together to provide Internet explorers with a virtual tour through the chest cavity of a mummy.

Diseases such as leprosy and tuberculosis have been diagnosed in the remains of mummies and the DNA from *Mycobacterium tuberculosis* has been extracted. Electron microscope analysis of liver tissue has indicated the presence of liver flukes, and lung tissue examination has yielded particles that indicated that the body of Nekht-Ankh had a sand pneumoconiosis. X-rays have shown nodules in the abdominal wall of mummies, which reveal remains of Guinea worms. Hydatid cysts caused by the dog tapeworm have been found in mummies by the use of an endoscope. Histological examination of muscle tissue of mummies has resulted in the isolation of parasitic infestations. Hair has been examined to help determine ethnicity. Immunohistochemical staining of tissue has advanced in such a manner that the identification of tumors and antibodies to certain cancers are noticeable in mummies.

Mummies of ancient Egypt have become symbols and an identity. This nationalism/mummy nationalism is largely due to the efforts of the Secretary General of the Supreme Council of Antiquities in Egypt, whose mission has been to publicize each new discovery, such as the recent identification of the mummy of Queen Hatshepsut, and to preserve the national monuments, mummies, and treasures. Museums that have mummies and artifacts from Egypt are being contacted and asked to return looted and confiscated items back to Egypt. These efforts resulted, for example, in the return to Egypt of the Ramesses I mummy in 2003 from the United States after having been on display for many years in a Niagara Falls, New York, museum and later in Atlanta, Georgia.

Keith Jacobi

See also Ancient Egyptian Beliefs and Traditions; Deities of Life and Death; Depictions of Death in Sculpture and Architecture; Egyptian Perceptions of Death in Antiquity

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Mummification, Contemporary

Principally, the process of mummification involves the desiccation of the body, thus differing from embalming, which substitutes bodily fluids for substances that slow down the process of decomposition. The ancient Egyptians perfected their technique over many hundreds of years. In the beginning, they struggled to achieve the same results that could be found within naturally desiccated bodies buried within the hot, dry desert sands. Their practice developed alongside religious and royal ideology, with the first individuals to be deliberately mummified being the Pharaohs of ancient Egypt in around 3400 B.C.E. The desire to achieve immortality through the preservation of the body became a practice that was extended down through the royal family, the nobility, and eventually the rest of the population. The treatment that was afforded the poor was of much lower quality than that given to the wealthy.

Contemporary Mummification

Today, a range of different methods are available concerning how the body is to be treated after death. However, the Church of Summum, based in Utah, prides itself on being the only organization to offer mummification as part of the funerary rites. It was publicly founded by Summum Bonem Amen Ra (formerly Claude Nowell) in 1975, taking inspiration from ancient Egyptian religious practices.

The term that Summum applies to their modern mummification procedure is "thanatogenetics." Although this mummification has been adapted from the original concepts of ancient Egyptian practices, their techniques for preserving the body have been extensively researched. Ra spent years perfecting the method with colleagues and students at the Lynn University, Boca Raton, Florida, using over 30 human and 40 animal cadavers to find the best way to preserve remains. The actual tools and formula used are a heavily guarded secret, despite the amount of media attention that the organization has received. At the end of the treatment, the body is wrapped in multiple layers of gauze and cast in "mummiform" fiberglass. The entire process is intended to ensure that putrefaction does not occur and the genetic structure of the body remains "at an optimum," which would in theory allow for DNA retrieval and perhaps the cloning of the deceased in the future.

The Church of Summum is a nonprofit organization, and costs for mummifying a family member or pet vary, with the money going toward the costs of materials used in the process. According to their website, this is a service that appeals to a variety of different people, ranging from those who feel drawn to elements of ancient belief systems to those who seek comfort in knowing that they will be preserved (and possibly remembered) for years to come. For many, inhumation and cremation are not desirable modes of burial, and therefore mummification may be the answer. The services proffered by Summum do not end with the mummification of the body. A special mausoleum "museum" is on offer to clients so that their bodies can be viewed and appreciated by family members, encouraging more of a relaxed and "at ease" view of death.

Even though the Church of Summum is fundamentally attempting to continue an ancient process, the fact remains that knowledge of many of the techniques employed by the ancient Egyptians are still lacking in detail. To learn more, a variety of different sources need to be studied—including the remains of the ancient Egyptians themselves. However, these bodies are precious and are embroiled in ethical

debates concerning their study and display. As a result, Egyptologists and scientists have had to seek alternate means to test their hypotheses.

In 1993, Bob Brier and Robert Wade, in conjunction with the Maryland School of Medicine, created a mummy based upon ancient Egyptian tools and techniques (including some 400 pounds of dry natron) applied to a modern human cadaver. The goal was to make a human mummy that would both macro- and microscopically stand the test of time. There are acknowledged difficulties in obtaining ancient DNA from Egyptian mummies, which would allow the study of genealogies, owing to problems such as degradation and contamination. Brier's experiment is thus a useful resource for the study of the impact of mummification upon molecular structures in the body.

Natural Mummification and Preservation

Contemporary mummification is not always deliberate, nor is it always desiccation that leads to a body's preservation. There are a number of natural ways in which a body may survive in an exceptional state of preservation without deliberate intervention. Furthermore, these relatively modern—often beautifully preserved—mummies can be found all over the world. Many act as testimonials to a religious way of life, ranging from the self-mummified bodies of Japanese Sokushinbutsu to the air-dried Capuchin monks of the Palmero catacombs, Italy. Others are the sometimes strange or tragic byproducts of the environment, providing an opportunity to see a snapshot of someone's last moments prior to death, such as the frozen corpses of members of the Franklin Expedition (1845–1859).

Finally, it would appear that "contemporary" mummification has different connotations to the "ancient" variety. The ancient Egyptians developed their techniques as a response to their religious beliefs and the environment in which they lived. Today, the reasons and methods behind mummification are as diverse at the people found in this state. Regardless, they all command respect and awe and have the ability to communicate something about themselves and the way in which they lived, even in death.

Gillian Scott

See also Ancient Egyptian Beliefs and Traditions; Embalming; Mummies of Ancient Egypt; Putrefaction Research

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Museums of Death

Museums are institutions that collect and display objects or artifacts of scientific, historic, cultural, or artistic value. Museums of death focus almost entirely on issues surrounding death, funerals, and memorialization in Western society, and on the objects produced as part of the mourning and memorialization processes. Since the 19th century, Europe, America, and many other countries have developed commercial enterprises surrounding funerals and mourning, while other societies and cultures have held onto traditional rituals of burial and memorialization. This entry describes collections that feature the wide range of death-related objects in different cultures and time periods in specialized museums of death.

Most museums of death are relatively new, having been founded within the past few decades. The reasons that this type of museum is now found to be more culturally acceptable are complex, but there are several factors to their growing popularity. Those factors include the deterioration of long-standing, primarily 20th-century taboos about public discussion of death and dying and the public displays of corpses, and an increased interest in the history of the rituals of burial and mourning.

An interesting point is that most of these museums do not explicitly call themselves "museums of death," rather they choose names that nevertheless reflect their related focus, for example The Museum of Funeral Customs in Springfield, Illinois; The Museum of Mourning Art in Drexel, Pennsylvania; or The Funeral Museum in Vienna, Austria. Museumgoers clearly understand what kinds of exhibits they will see, and that these will be related to death and dying in some way. Some museums take a kitsch, pop-culture approach, using humor as part of their message—for example, the motto of The National Museum of Funeral History in Houston, Texas is "Any day above ground is a good one." In general, however, these museums do not attempt to glamorize, romanticize, or glorify death, as often happens in films, rather their focus is on presenting objects and information in a historically accurate and culturally interesting way to foster discussion about how modern societies have dealt with death, dying, and mourning.

Caskets

Typically, the most prominent display for any funeral museum is the collection of coffins and caskets. In America, until the 19th century, coffins were usually made by a local carpenter or cabinetmaker who made up a simple wooden box on demand. Later, as the preparation and display of the deceased was increasingly taken over from the family by commercially run funeral parlors, the coffin business also specialized. "Caskets," or fancy coffins, became popular through clever marketing; these take their name from Renaissance jewelry boxes—an appealing name to the bereaved, evoking the thought of treating their beloved as they would a "precious gem." Caskets often feature luxurious interior fabrics (e.g., silk), and ornamental hardware—handles and name plates—of brass, gold, or silver. Catalogs for this hardware dating from the 19th century are veritable treasure troves of 19th century design. Some museums, for example The National Museum of Funeral History (Houston, Texas), also display innovative coffins or oddities, for example the "cooling" coffin that, in the days before refrigeration, allowed for the inclusion of ice to help delay putrefaction. Other things related to funeral culture and burial, such as shrouds, are often also included in funeral museum exhibits.

Of European museums of death and funeral culture, the Vienna Funeral Museum is probably the best known. Founded as an extension of the Viennese Municipal Funeral Department, the museum presents the history of Austrian, and specifically Viennese, burial and funeral history through the department's own collections and business papers, including coffins and hearses. However, museums specializing in funerary art, history, and culture can be found all over Europe, including in major cities, such as London, England; Paris, France; Amsterdam, the Netherlands; Budapest, Hungary; and Hamburg, Germany. The Museum for Sepulchral Culture in Kassel, Germany, specializes in the history of monuments.

Funeral Vehicles

Hearses, or conveyances to transport the dead, form another major component of many funeral museums. Before the 19th century, coffins were either carried by mourners to the graveyard or taken by horse and cart, a utilitarian mode of transport that was used for many different purposes on a daily basis. The development of a specialized vehicle to transport coffins and caskets dates from the 19th century; these vehicles were often splendidly outfitted, with sumptuous and plush interior upholstery, draperies, tassels, and exterior decorations. The more important the dead, the fancier the hearse used—sometimes including pairs of color-matched horses with large plume headdresses and ornate harnesses. Since the advent of the automobile, hearses are now usually black cars, with some vestiges of 19th century black drapery. Occasionally, museums display unusual hearses, for example the Mercedes hearse that transported Princess Caroline of Monaco at her funeral. The Museu de Carrosses Funebres (Museum of Funeral Hearses) in Barcelona, Spain, has in its collection hearses dating from the 18th to the mid-20th centuries, and includes ornate baroque horse-drawn carriages, as well as a silver Buick, and white carriages that were used for children and virgins.

Embalming

Another compelling subject for such museums is the topic of embalming. Embalming has been

practiced in one form or another since ancient times—Ancient Egypt is the best known, but other civilizations including the Incas and ancient Chinese also used it as part of preservation and mummification techniques. While embalming largely fell out of favor for centuries in Europe, in America techniques for efficient and sanitary embalming were developed, particularly during the American Civil War (1861–1865), when family members seeking the return of their war dead helped to popularize the practice. Museums often display different types of embalming techniques and products through the years, and the advances in embalming equipment that have been developed.

Mourning Collections

Some museums specialize in collecting and displaying the large variety of objects that are related to mourning and remembrance. In early America, tokens, such as gloves or rings, were given out during funerals to eminent attendees; these are now found in some museum collections. George Washington's death in 1799 was the first to generate widespread public mourning in America. For years after, artifacts were commercially produced to commemorate Washington's death, including lithographs, handkerchiefs, and ceramics showing images of mourners at Washington's gravesite. Young schoolgirls were taught to paint or embroider fancy pictures commemorating the deceased members of their families; these became treasured heirlooms. These objects, whether commercially produced or personally crafted, tell of the history of mourning.

The 19th century witnessed the development of elaborate rituals and objects of mourning in Western European and American history, wherein Queen Victoria was extremely influential. Upon the death of Prince Albert in 1861, the Queen embarked on a prolonged period of private mourning that lasted until her own death in 1901. Queen Victoria's private grief and her public role as the longest reigning monarch in English history helped to promote the development of an array of artifacts to publicly express one's status as a mourner and to preserve the memory of the deceased. Widows were expected to adhere to a rigid series of stages in their dress, behavior, and interactions with the outside world for up to several years. Color was the primary indicator of the degree of mourning. During the early "full" or "deep" mourning period, women wore either all black or all white. Men were also expected to wear dark clothes, but for shorter periods. Later stages of mourning allowed for a gradual return to color, first gray, then in the final stage, purple or violet. Accessories such as gloves, hats, fans, and handkerchiefs conformed to these colors. Specialized stores and department stores were important purveyors of mourning goods, including the black-bordered stationery (with different-sized borders, depending on the mourning stage) used during the mourning period. Crape, a type of fabric, was especially associated with mourning clothes, and was also used to drape front doors or buildings to signify public or national mourning, such as in the period following the assassination of President Lincoln in 1865. All of these types of objects—clothes, accessories, fabric, and stationery—are often exhibited by museums interested in the history of death and dying.

Yet another significant category of museum death-related collections is mourning jewelry. From the late 18th century onward, mourning rings, brooches, cameos, bracelets, necklaces, and pendants appear in great and elaborate varieties—some with images of urns (a classical motif referring to the ashes of the deceased), some containing hair of the deceased, often with small pearls, and others made simply of black jet, a stone made popular by Queen Victoria.

Postmortem Photography

Technological developments also spurred the growth of another mourning-related industry, the postmortem photograph. After the introduction of photography in 1839, photography studios soon flourished in many towns and cities across America. One specific service of the photographer was to visit the home of the bereaved to take a photograph of the deceased, either posed in some way to appear alive (or if an infant, in the mother's arms), or lying in the casket. A postmortem photograph allowed a mourner to retain a visual representation of the deceased. Although this practice was fairly common in 19th-century America (less so in Great Britain), these photographs today are relatively rare and often make their way into museum exhibits as

oddities. Postmortem photography is still used today, particularly as a therapeutic tool for parents who have lost a baby or a young child; these images may one day form future museum exhibits.

Ephemera

Other types of mourning artifacts were of a more ephemeral nature—that is, they were not necessarily meant to be useful beyond the period of mourning, although sometimes these objects survived anyway, saved by family members and friends. Such artifacts include the memorial cards handed out at the funeral. These cards, usually black (or white, for children and occasionally women) with gilt-edging and gold print, were bulk printed, and contained the name of the deceased, birth and death dates, and usually a standard verse or poem. Some artifacts were disseminated in great numbers during the mourning for a national figure, for example black-edged ribbons and memorial cards for President Lincoln. Today, funeral programs and cards from the mid- and late 20th century are of considerable interest to museum curators, since objects like these form part of the continuum of the history of mourning and funeral practices.

Conclusion

Museums that deal with death-related topics and artifacts don't just collect ancient "relics" or antique objects, or focus on Europe and America. Contemporary objects such as 19th- and 20th-century funeral home items—for example, fans or calendars distributed by the business, funeral programs, or monument catalogs from various companies—are also of interest to historians and museumgoers. Additionally, foreign or exotic civilizations and cultures are often well represented in large, general audience, natural history museums, with inclusion of their death and burial-related artifacts. Museums about death, dying, and funerals thus present varied aspects and culturally different ways of memorializing death, dying, and bereavement throughout history.

Elise Madeleine Ciregna

See also Caskets and the Casket Industry; Clothing and Fashion, Death-Related; Depictions of Death in Art Form; Embalming; Funeral Conveyances; Funerals; Grief, Bereavement, and Mourning in Historical Perspective; Memorials; Popular Culture and Images of Death

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Muslim Beliefs and Traditions

In Islam, spiritual belief refers to the existence of God and the total belief in the One and only God, Allah, and that Muhammad, the Prophet, is His messenger (*Kalimah Shahadah*). The basic fundamental beliefs of the Muslims, followers of Islam, are the true understanding of and total belief in the oneness of God (Allah). It is the first tenet in Islam. Everything that is done by a Muslim is directed to only one thing—to gain Allah's pleasure and blessings.

Muslims are guided by two major references, the Qur'an, the Islamic Scripture, and As-sunnah, the practice of the Prophet. For Muslims, the understanding of death, life, and the purpose of life derive from these sources. Every Muslim believes that there is life after death and, as stated in Islam's Six Pillars of Faith, life on earth is not as important as life in the hereafter.

The Purpose of the Creation of Human Beings

In Islam, to understand death, it is essential to discuss life, living, and its purpose. It is fundamentally

important to know, before death comes upon us, the purpose of man's creation. In fact, a Western view also agrees that loss through death must be experienced in order to understand the questions relating to life, death, and purpose.

In welcoming the newborn into a Muslim family, the *Azan* (ritual call to prayer) is said in the right ear of the child, and the *Iqamah* (ritual call to initiate congregational prayer) in the left ear. Those words are the first thing a Muslim child hears after coming into this world—the attestation of the belief and the call to worship the Creator. In Islam, life prepares a person to die. The Qur'an provides a complete guide as to how one should lead one's life. In life, one must submit oneself to Allah; one must learn to know and serve Allah. The Islamic concept of *Ibadah* (servitude) means that everything one does will result in getting a reward from Allah, provided that one does it in the cause of Allah.

Human beings have been placed at the highest rank of creation. We have been chosen to be God's vicegerent on earth and have been given the responsibilities, the duties, and the trust to ensure peace on earth. Above all, human beings are created with one ultimate purpose, to seek the pleasure of Allah. Therefore, how one leads one's life will determine how life after death will be for that person. Two important assumptions about life that affect one's death are accountability of behavior and life is a test.

Accountability of Behavior

All actions on earth determine one's place in the life hereafter. One is accountable for every single action and even the smallest events. In fact, happiness is mentioned twice in the Qur'an and both times refer to the life hereafter, not the life on earth. According to Sharif Muhammad, success is not measured by what we have in life. Instead, real success is one's ability to be saved from the punishment of hell and be admitted to paradise.

It is impressed upon all Muslims to be balanced in life so that life on earth is not abandoned in the hope for better life in the hereafter. Being balanced is about fulfilling the roles and responsibilities that one will be accountable for in the life hereafter. Besides the responsibility as a Muslim to submit to Allah, neglecting one's responsibilities to others, such as family, parents, neighbors, and employers, on earth may also result in later punishment.

Life Is a Test

The emphasis on life after death has made death a bridge or a transition from life on earth to the life hereafter. Life and death are created as a test to find who among us is the most righteous. Everyone will die, and this life on earth is just probation, during which one's faith will be tested by many things. Some are tested by calamities and some are tested by good things, but in the end all will return to Allah so that, based on merit, judgment is rendered.

As stated in the Qur'an, people shall be tested by fear, hunger, and loss, and Allah has created life and death with a purpose and a supreme wisdom. We are tested by both bad and good things, and life and death are created as tests. Allah only tests those who are capable of being tested, as He knows one's ability to handle the resulting stress. Muslims rejoice that Allah has promised that every test will end with relief. Islam explains death in full detail, how it happens, and what Muslims should do before, during, and after death.

Death in Islam: Important Concepts

1. Return to the Creator—Death is the time for man to return to the creator.
2. There is no escape from death—When the time comes for someone to die, it is impossible to escape from it.
3. Death is for everyone, regardless of age—Allah has not made a distinction between who dies first, the young or the old, the rich or the poor.
4. Time of death is unknown to us—No one has the slightest idea of when one is going to die.
5. All the actions stop after death—There is no turning back or bargaining for more time, as Allah has given us ample time to do our best deeds. Belated regrets or awareness are no good to anyone.
6. Death is not our final destination—Death is not the final destination in Islam. This is clearly stated in the tenets of Faith (*Iman*); all Muslim believe there is another life after death.

Life After Death: What Happens When a Person Dies?

Death is a day of judgment and a transition to the eternal world. A dead person will return to their origin. The physical or material aspect will return to earth buried in the grave; the spiritual aspect of man will return to its Creator, Allah. The *ruh* that was once breathed onto man will be lifted and returned to Allah, the Creator. It is a promise that every human has made to Allah upon his or her completion (as He breathed in His ruh in us) that one will return to Him, the Creator.

The Day of Judgment is the day when all deeds will be weighed. We make no defense, but must take responsibility for our behavior. Parts of the body, such as hands, legs, stomach, and eyes, will bear witness to one's sinful behavior. The good will go to heaven and the sinful will have to pay for their sins.

Role of Community: Relatives, Friends, and Neighbors

In Islam, care is extended to the family of the deceased by comforting the relatives, sharing their sorrow, and offering condolences, sympathy, and support. The necessary funeral preparation must take place immediately. Friends, relatives, and neighbors will help with the preparations, as the burial must be done almost immediately. In Malaysia, for example, a group of four or five trained individuals will be responsible for funeral preparation. They are not paid for this service to the community. But normally, the family of the deceased will give a token of appreciation in the form of money, clothing, or anything that the family can afford. Families, friends, and neighbors come to visit and offer condolences to the bereaved families.

Coping With Death

Every true Muslim has been exposed to the basic understanding of death. It is the understanding and belief in the concept of Divine Will (*Al Qada* and *Qadar*) that affect one's acceptance of death. This knowledge, in the first place, helps a person cope with loss when death occurs. Muslims are asked to prepare for their own death because one's life and death are in the hands of Allah and no one knows the exact time of their death.

Although life after death (*Alam Barzakh*) is an invisible phenomenon and hence inconceivable by worldly means, Muslims are encouraged to contemplate death through God's creations. As Muslims contemplate the lives of human beings in the darkness of the embryonic stage and compare it with life after birth as one grows into adulthood, then by extension, one can visualize the vastness of what one will experience after one is freed by death.

We can observe the influence of the important elements of the Muslim religious belief system and its acceptance of death as divine will as reported in the research finding of how death is dealt in a Malay community. A study of a close family member's death among Malay Muslims conducted in 2005 to 2006 reveals three types of responses toward death: (1) universal response, (2) religious spiritually inclined response, and (3) Malay ethnic-cultural responses. Universal coping responses include shock, denial, and the rejection of the news of death. Religious spiritually inclined responses are praying and making *doa* (supplication) as well as reciting Qur'anic verses, *Yaseen*. Not long after the initial reaction of disbelief, many Muslim Malays turn to religious teaching as a coping mechanism. Malay ethnic-cultural responses include visiting the grave on specific occasions, a symbolic initiative important to the living, and holding small gathering or feast for relatives and close friends for 3 or 7 consecutive days, followed by the 40th day and 100th day. This study clearly demonstrates that the remembering of death is a significant coping mechanism for Muslims regardless of how one reacts initially to the news of the death of a loved one. For Muslims, the knowledge of the Islamic view of death, a view that death is in the hands of Allah, serves an important means through which they can face death, cope with and deal with social and personal life changes after death of a loved one, as well as prepare for the life hereafter. Hence, Muslim beliefs and knowledge help a Muslim be more prepared by doing things that will bring happiness to their life hereafter despite the fact they still have fear and anxiety to accept the "real" death.

Haniza Rais and
Nik Suryani Nik Abd Rahman

See also Christian Beliefs and Traditions; Death Anxiety; Grief, Bereavement, and Mourning in Cross-Cultural Perspective; Symbols of Death and *Memento Mori*

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Mythology

Mythology is a wide-ranging area of research that focuses on the development of individual identity, making the cosmos intelligible, social understanding as a collective experience, spirituality, the concept of birth and death, cultural awareness, and the relationships between these entities. It was in the 1920s that the ethnographic work of James Frazier and Joseph Campbell provided the foundational understanding of these elements and the current ideas in the field. From their work, current researchers in this area see death as a pivotal aspect, believing it to be the one unifying fear of all humanity that is expressed in narrative forms. This domain does not have a single definition of death, as the basic premise of myth is that individuals seek to understand their life-death connections as an individual emotional response. This is the case even when the individual subscribes to a collective religious belief system.

Hence, mythic response has lead to the development of a myriad of religious or spiritual beliefs, rites, and narratives. However, despite the variations, researchers in this discipline have recognized that because all of humanity are faced with death, similar themes emerge in the mythic narratives. The rituals, images, and language that describe and explain death over time and the cultural variations as well as the similar themes regarding these life-death relationships are the grist of mythic investigation with the core of understanding myths centering on three questions: Who am I? Where have I come from? and Where am I going? How individuals and groups answer these questions is related to their explanation of death within an interpretation of life.

In the death myths across the spectrum of current religious understanding, including Christianity's belief of entry into heaven after death, Buddhism's cycle of reincarnation, and Islam's rites of burial and entry into heaven, there is a universal underpinning that death is a condition of hopeful transformation. This mythic ideal of transformation has arisen due to the natural decomposition process, whether from burial or cremation, and in light of this, if life is to be meaningful there needs to be a sense death is one aspect of living representing entry into another form.

It is also generally accepted that all secular narratives place death as the core element, and that whether secular or religious, the narratives have a similar underlying theme of "death as living leading to transformation." The concept of death and associated mythic meanings of change are embedded in narrative through a series of connected metaphorical layers of narrative patterns, words, and visual symbols.

Textual Myths: The Quest and Death of the Hero

Across cultures, myths rely on a central characteristic of undertaking a quest. In these quests there

are sections of plot, such as call to change, overcoming personal issues, finding personal understanding, overcoming real or imagined monsters, and achieving a goal, all of which lead to the death of the hero. These plot transformation processes allow us to read and see firsthand the transformation in life of a fictional character and how life can be a preparation for death.

Because of our universal fear of dying, all of the death aspects related to a fictional hero are also linked to the need to comprehend the inevitability of our own death and our fear of purification. Although far removed from us in time and place, the function of these mythic encounters is to both allow us to continually confront this fear as well as reveal afresh how someone else answered the three great "life questions" as they came to face the one common human denominator of death. These death experiences take many forms but are typically linked in some way to the concept of sacrifice, in that living and dying for others is the path to finding genuine fulfillment in this life, leading to transformation into the next. The textual facets of death are as follows:

The Scapegoat Death. It has been suggested that this mode of heroic death occurs in some form in all narratives. Embedded in all cultures and in all of the major religious literature, this facet is typically linked to the notion of a messianic figure expunging all sin through a sacrificial death. The notion of the scapegoat is a long-held precept and predates the contemporary narratives of Christianity, Islam, and Judaism by millennia. The occurrence and need for a scapegoat death is a metaphor for the existence of social disorder and chaos in a culture when the hope for peace and security has faded and there is a need for cleansing or a new beginning. Mythically speaking, the point of this form of death by a leader is sacrificial in that their death is in place of that of another member of society. It is, therefore, the pinnacle of mythic narrative, as this single death is the transition point among disharmony, disunity, and the ushering in of a new order of peace. This mythic death narrative underpins many religious narratives in that belief in a scapegoat figure ensures transformation after death into a new eternal life of peace. It is accepted in this field of research that the death myths of Christ, Mohammed, and Buddha all have aspects of this narrative form.

The Heroic Death. Linked to the notion of the "good death," or the death that results from a battle with evil, this mythic form serves to usher in an era of peace. However, the "heroic death" also reveals how alone the hero is, thus relating to the solitary nature of death. Almost always a male, the hero is the victorious warrior. Having high social status, he is able to fit well into that social scene. But his death narrative reveals the sense of isolation all humanity encounters at the end of life. This death myth is often revealed as a massive fall, being struck down by a powerful blow. This idea of "falling" is a metaphor for one's humanity and ultimate end. Current drama and action movies such as *300, Sin City,* and *The Departed,* use this form of mythic narrative, as do the current television series dealing with the afterlife and police investigations, and many animated visual forms.

The Maternal Death. While there are few female heroic central characters in narrative, and therefore few heroic deaths, the female death motif is nonetheless an important facet of myth storytelling. Just as the heroic male death is linked to sacrifice, the female death in myth is linked in a similar fashion to the concept of martyrdom as a transformative death. Rarely is the female death portrayed in the same light as the powerful death of the male warrior form. Even when there is a portrayal of the female combatant, her death is often portrayed as either one that occurs in childbirth or metaphorically linked to the birth experience; itself a mythic metaphor of transforming from one world to the next. Although the male dies a powerful warrior death portrayed as a fall, the female dies a painful death being bound or as she either literally or metaphorically gives birth to a new "warrior-to-be" child. This form of mythic death experience is seen to be one of submission, wherein the female is willing to give her life as part of the female role so that another may live. While submissive in mythic terms, it is not secondary to the male death or role in life but more substantive in that it is only through the female that life can begin. The maternal death form is also emblematic of the life cycle myth, as it prefigures the conception of the warrior or hero in the bridal bed, and the possibility that he too will finally die as he was born, immersed in blood and suffering, having his

own flesh ruptured. For mythic researchers, the story of Joan of Arc and, more recently, the female movie deaths of Carrie White in *Carrie,* Spiderman's girlfriend Gwen Stacey, and Ellen Ripley in *Alien 3,* all represent this form of death experience.

The Evil Death. While conflict between good and evil is a major theme, this encounter has several meanings. Often cast as a clash between light and dark, the opposition to the heroic force is almost always deemed deserving of death. Good must prevail and destroy this source of evil energy. And while death comes to this being, this war represents the hero fighting against self and the evil within. The evil shadow that is being portrayed represents the evil in us all, thus making us deserving of death. If the hero does not suffer a martyr's death, then this causality is often revealed at the end of the narrative, with the heroic figure being overcome by the dark twin of death. The death of Gollum in *Lord of the Rings* is a case in point.

Words and Death Mythology

Lexical terms such as *grave* are an obvious reference to death. However, despite the personal and cultural variations, narratives also contain an array of words that prompt one's contemplation of death. These include terms such as *skull, crucifixion,* and *eternity*. This pool of language is believed to be based on narratives we hear as children. However, concepts such as *bereavement* eventually become taboo subjects. Elements of the afterlife abound in children's stories, but these words remind us of our mortality.

Thus, these words create focused projections of past narratives, personal encounters, and images of death that we have seen or experienced. In a sense, these projections forecast our demise and thus force us to confront a reality that extends beyond the experience of everyday life to include the concept of life after death, spirituality, and religion.

Visual Depictions of Death

Perhaps the most cogent form of mythic symbolism is the use of shapes, lines, and connected visual elements that are found in buildings and paintings. Even the most simple forms, such as circles, and all forms of places of worship have a deep spiritual meaning. One example is the circle of Neolithic times that symbolizes the conjoining of earth and sky. Over the millennia, this meaning has transformed into the zodiac sign of Gemini, the wedding band and its hope for eternity, the four gospels of the Christian cannon, and overarching representation of atonement and freedom from the bonds of death.

In recent times, the depth of meaning of these symbolic forms is increasingly being realized. Mythologists, archeologists, and ethnographers have made connections between the death masks found in Asia and the animal motifs and depictions of knots and circular patterns found elsewhere on churches, temples, and mosques. In relation to death, there is a vast array of visual emblems that are recognizable through the simplest of forms. One example of an ancient emblem is the Christian cross that adorns graves around the world. It is a physical marker of death, but it also symbolizes the hope of new life and a new beginning. The cross represents the heroic death of a messianic figure willing to assume humanity's evil. This symbolism is derived from the Neolithic death narrative of Tamuz, son of Astarte, a prototype story for both Christian and Jewish messianic narratives as it details the virgin birth of Tammuz, his sacrificial heroic death, and his mother's rebirth on the winter solstice of December 25. Scholars view the continuation of this death narrative as being manifested in the Christian memorial of serving Hot Cross buns at Easter, with the cross representing the "T" for Tammuz and Easter being a modern linguistic version of Astarte. Death as myth simply becomes translated into similar patterns that hold different cultural meanings.

Across time and cultures, the site of death has been marked by similar illustrative rituals that articulate death as both an end as well as a new beginning. Perhaps the oldest iconic element that deals with death and life is the labyrinth. While now representing a circle, such as a wedding band, the circular spiral form represents descent into death as well as the path that leads away from death. The labyrinth represents an enduring symbol found in burial and funeral sites across the globe in elements as simple as patterned tiles on graves. It is through mythic analysis that this form can be seen as emblematic of the cycle of life that

includes death as an integral component, all in a world that appears to have been demythologized.

Phil Fitzsimmons

See also Good Death; Mortuary Rites; Mythology; Spirituality

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Near-Death Experiences

Because of 20th-century advancements in resuscitation technology, people in numbers unprecedented in human history were returning from the brink of death reporting distinct psychological experiences with transcendental and mystical features that profoundly changed them. In 1975, psychiatrist and philosopher Raymond Moody Jr. first termed this as a near-death experience (NDE) and informed the public and most professionals about NDEs. By 2005, authors had published numerous books and over 800 refereed journal articles on the subject. In these publications, researchers reported on more than 65 studies involving over 2,500 near-death experients (the people experiencing NDEs). In these studies, they addressed the content and aftereffects of NDEs, the circumstances and incidences surrounding the experiences, and the characteristics of near-death experients. Researchers and NDE theorists also addressed the implications of NDEs for an understanding of death and the nature of consciousness. Following is a summary of 30 years of research and theory on these topics, as well as future directions in the field of near-death studies.

NDE Features and Aftereffects

Researchers have divided NDEs into two categories based on their predominant emotional tone and content: pleasurable and distressing. In both types, most near-death experients are adamant that their NDEs were as real or more real than their usual experience of reality and that their NDEs were different than dreaming, hallucination, or other familiar or known altered states of consciousness.

In pleasurable NDEs—those dominated by feelings such as peace, joy, and love—the number and combination of reported features varies but includes one or more of the following: total peace; separation of one's consciousness or sense of self from the body; observing the body and/or its surroundings; rapid movement through a non-earthly tunnel or void, usually toward a light; entry into the light, then perceived as an all-knowing, all-loving being; a life review, involving re-viewing and reexperiencing every moment of one's life and, simultaneously, being everyone on the receiving end of one's actions; encountering beautiful scenery and/or music; encountering deceased loved ones or other spiritual entities with whom one communicates telepathically; encountering a border or limit; and either voluntary or involuntary return to the body, which the experient may not specifically recall or may recall having been through any of a variety of bodily locations such as the head, chest, or whole body. Near-death experients usually report a sense of timelessness in the NDE and sometimes report omniscience and/or having been shown past lives or future events.

Physical aftereffects of pleasurable NDEs can include a sense of confinement in the body that usually resolves relatively quickly; light and sound sensitivity that may or may not linger; increased allergic and medication sensitivity; and electromagnetic

effects in the experient's vicinity, such as the malfunctioning of lights, computers, cell phones, and watch batteries. Short-term psychological aftereffects can include anger, sadness, and/or longing related to a sense of loss of the often profoundly pleasurable NDE; relief at being alive; frustration at the inability to adequately describe the ineffable/indescribable quality of the NDE; fear of being disbelieved, pathologized, or demonized; and withdrawal from others or preoccupation with telling others about the NDE. Long-term psychological aftereffects can include a total loss of fear of death (an almost universal experience following pleasurable NDEs); an increased sense of self-acceptance; empathy for others; caring and love for humanity; an appreciation for nature and life; altruism and sense of service; a sense of detachment; a sense of alienation; compulsion to read and learn; a decreased tolerance for violence; and a decreased interest in wealth and fame. Social aftereffects can include isolation or frequent retelling of the NDE; testing in social relationships to determine safety to disclose the NDE without fear of negative reaction; family and friend relationship stress and changes related to the experient's psychological changes, including increased incidence of divorce; and career changes, often in the direction of greater social service. Spiritual aftereffects can include an ongoing sense of connection to a higher power or domain and/or to humanity, life, or the cosmos; religious or spiritual difficulties, especially if the NDE diverged profoundly from the experient's previous worldview, as it often does; leaving or becoming more deeply involved in organized religion; increased psychic experiences; ability to heal others; and an enhanced sense of meaning in life, especially that the purpose of life is primarily twofold: to develop in the capacity to love and to learn—to acquire knowledge.

Much less frequently, some near-death experients report NDEs dominated by distressing feelings such as confusion, powerlessness, isolation, guilt, or horror, usually resulting in terror. Researchers have identified four types of distressing NDEs. Most distressing near-death experients have reported the same features as pleasurable NDEs but feeling fearful, which some researchers believe is associated with near-death experients' resistance to the unfolding NDE. Next most often, distressing near-death experients have described hyperawareness of total isolation in an absolute and eternal void. Even less frequently, distressing near-death experients have described "hellish" experiences involving torment and suffering. Rarest of all are reports of feeling negatively judged by a higher power.

Aftereffects of distressing NDEs are quite similar to those of pleasurable NDEs except for a higher incidence of relief at being alive and lower incidence of the loss of fear of death—at least in the short term following the experience. Most distressing near-death experients perceive the NDE as a warning and respond by reforming themselves in some way. For a variety of reasons, some near-death experients foreclose on reflection on the experience, and a few retain an open, searching attitude regarding the experience and its meaning for their lives.

Incidence and Characteristics of NDEs

Research has not yet clearly revealed the exact incidence of NDEs. Different types of studies have yielded rates ranging from 10% to 35% of people in situations of actual or threatened severe illness or physical or emotional injury. Researchers continue to debate NDE incidence.

No demographic variables predict whether or not a person in a near-death situation will later report an NDE or whether, if an NDE is reported, it will be pleasurable or distressing. Nonpredictive variables include age, sex, socioeconomic status, education level, sexual orientation, preexisting beliefs, history of prosocial or antisocial acts, mental health status, and circumstances of the near-death situation. Perhaps most notable is that both pleasurable and distressing near-death experients are just as mentally healthy as nonexperients, just as likely to have a history that includes or excludes deeds that society tends to consider good or bad, and just as likely to be devoutly religious or spiritual or disbelieving in any religious or spiritual belief system. Children's NDEs do not differ substantially from adults' NDEs. Also, NDEs resulting from combat or suicide do not differ from those resulting from natural illness or unintentional accidents—though near-death experients in general, and those whose NDEs were the result of suicide attempts, are usually strongly committed to suicide prevention because of the conviction that each life has meaning and purpose. Some researchers

have found among near-death experients a higher level of psychological absorption—the tendency to become deeply absorbed in an object of attention. However, because the spontaneous nature and relative infrequency of NDEs makes them difficult to study, it is unknown whether this characteristic occurred after, and perhaps as a result of the NDE, or if it preexisted, and perhaps facilitated, the NDE.

Because most researchers have conducted studies in the United States and other Western countries, less is known about non-Western NDEs. Members of many non-Western cultures have reported NDEs, and their content has reflected their cultures. A few features can be considered truly universal, such as encounter with spiritual entities and the experience of an otherworldly social system. Another possibly universal characteristic is encountering a border or limit beyond which near-death experients sense they would not be able to return to physical existence. Most researchers have concluded that culture clearly contributes to, but does not entirely explain, NDEs.

Implication of NDEs for Understanding Death and the Nature of Human Consciousness

Most near-death experients say that, as a result of the experience, they do not merely believe, but actually know, that their consciousness will survive their physical death. Some people who have not experienced, but have learned about, NDEs have drawn similar conclusions. However, from a purely scientific perspective, NDEs cannot provide evidence of the *ongoing* survival of consciousness, because no experient *remained* dead. To scientifically study the phenomenon of *ongoing* consciousness, researchers would need to directly study people who are *irreversibly* dead—a notoriously difficult research population. Thus, from a scientific perspective, NDEs can, at best, narrow but not close the gap in the leap of faith regarding the survival of consciousness.

Another question that several authors have addressed is the "reality" of the NDE. Arguments have fallen into one of two categories: material and nonmaterial. Materialist explanations rest on the assertion that the NDE can be reduced to brain function, specifically the physiology of the dying brain. Chief among these hypotheses is that NDE phenomena are the result of lack of oxygen to the brain. Nonmaterialist explanations rest on the assertion that NDE phenomena cannot be reduced to brain function. Chief among these hypotheses is that nonphysical, veridical perception occurs in NDEs. In numerous cases of veridical perception, near-death experients have reportedly perceived unanticipated objects or occurrences in the physical world during their NDEs that, based on the condition and/or location of their physical bodies, they should not have been able to perceive—yet the perceptions were subsequently shown to be accurate. Authors and researchers continue to debate material and nonmaterial interpretations and explanations of NDEs.

Future Directions in the Field of Near-Death Studies

Despite substantial research into NDEs and their aftereffects, much information remains to be known about them. Consequently, researchers are continuing to study them, with emphasis on certain aspects. One aspect is the extent to which near-death experients manifest changes that, by the standards of any major religion, would be considered spiritual. Another aspect is the extent to which near-death experients compose an "at-risk" group (at risk after their NDEs for distress and/or dysfunction in the physical, psychological, social, and/or spiritual domains). A related aspect is how health care providers can be most helpful to near-death experients and their associates. Because NDEs typically involve near-death experients' immersion into an alternate reality that they neither expected nor felt prepared to understand or integrate following the experience, health care providers from every field—medical, mental, social, and spiritual—have a role to play in helping near-death experients and their families, friends, coworkers, and other associates. The goal of ongoing research is to determine how to promote the greatest holistic well-being for everyone affected by the NDE.

Other research directions more broadly address the nature of death and consciousness. In these efforts, researchers are attempting to move beyond the less scientifically valued collection of anecdotes toward the more valued study conducted under controlled scientific conditions. One focus of this type of effort is veridical perception: Typically,

these researchers conduct hospital studies involving targets visible only from the vantage point of the ceiling, hoping that, over time, a number of resuscitants will describe NDEs in which they accurately report the content of the target. Another focus is electromagnetic and healing aftereffects of NDEs: Researchers are conducting surveys to determine the extent of these phenomena and planning studies in which they attempt to measure the electromagnetic correlates of them.

In conclusion, advances in resuscitation technology have resulted in numbers of NDEs unprecedented in human history. These experiences provide humanity with a unique perspective on the human experience of death. NDEs are likely to continue to occur, and ongoing research into them may provide a basis for health care providers to be most helpful to people that NDEs have affected and provide novel insights into the nature of death and human consciousness.

Janice Miner Holden

See also Communicating With the Dead; Defining and Conceptualizing Death; Life Review; Popular Culture and Images of Death; Reincarnation; Resurrection; Resuscitation

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Necromancy

Necromancy is defined as the ability of a sage, shaman, or priest to raise the dead from the grave and communicate with them as one would talk normally with the living. The word itself is derived from the Greek words of *necros* (meaning the dead, the departed, or a specific reference to the corpse) and *manteia* (which has overlapping meanings of foretelling, to summon forth, and divination).

Of all religious practices this "summoning forth" or "calling up of the dead" has perhaps the longest history and the broadest cultural practice. Seemingly common to many cultures across human history, the clearest, but still scant, anthropological evidence of this ritual places its origin, or at least consolidation as common practice, in the Neolithic Era in many areas of Europe. It is speculated that in this area it was an integral component in the worship of Saturn, who in turn became Poseidon in later centuries. While there is little direct evidence of its development, it is speculated that necromancy then became an integral ritualized component of the evolutionary growth of this form of worship as it extended into the religious polytheistic religions of the ancient civilizations surrounding the Mediterranean and the Far East. Thus it became one of the cornerstone practices in the religions of the Canaanites, Egypt, Greece, and Rome. Each of these cultures carried this practice forward as they continued to develop and expand, whereby it also became a common ritual in Persia, the greater Babylonian Empire, and the later occidental religions.

The relatively small amount of ethnographic and anthropological research reveals that in other parts of the globe, such as Polynesia and the Caribbean, necromancy has been considered to be a normal religious exercise by societies that practice voodoo. Although there is little research focus in this area, in other religions, such as Judaism and Christian communities, it is considered to be taboo. This belief is centered on the banning of this practice by texts such as the Old Testament book of Deuteronomy (18:11) and as exemplified in the narrative in 1 Samuel 28, where the witch of Endor calls up the prophet Samuel for King Saul. Interestingly, the text does not state it was a counterfeit vision or a disguised demonic form, although many Old Testament and Christian scholars assume this is the case. Herein lie the core elements for those groups that assert the validity of this practice and those that uphold its categorization as being taboo. First, a key facet of necromancy lies in the theological notion of the "resurrection." For Christianity, Islam, and Judaism, only God or Allah can genuinely breathe life into and raise the dead, and for

these religions this is commonly believed to occur at the Last Judgment. Thus, practitioners of necromancy are seen to be taking on the role of the creator and sustainer of human life, which is a theological anathema for these religions.

Related to this concept of only God being able to create or recreate life is the current debate surrounding what theologians call "the state of the dead." In regard to necromancy in particular and the concept of death in general, the contemporary focus has been on several key Old Testament verses that seem to indicate that the term *soul* means a "life force" and not an entity capable of existence of its own accord, that the body and soul are a single entity, and that death becomes an unqualified sleep until the Last Judgment. Therefore necromancy would not fit within the parameters of this theological position of the soul or life existing after death.

For these reasons, in many areas of religious practice, theological research, and religious study necromancy is considered to be perhaps the most demonic or the blackest of all religious forms. For whatever reason, it is still typically believed by many religions that "calling forth the dead" steps into the domain of the devil or Satan, who has claimed the body or the soul as his own because the corpse itself was laid to rest in the ground, which many theologians and anthropologists deem to be classed as his territory.

Thus, in some societies and religious groups, both past and present, the priests had to protect themselves through the use of various symbols, which could include a blood sacrifice as means of atonement, the drawing of a circle on the ground to represent uninterrupted protection, burning incense to symbolize the protective shielding by a higher power (and the rising of protective prayers), and the use of symbolic forms and words drawn within the circle to offer protection.

Phil Fitzsimmons

See also Armageddon; Resurrection; Spiritualist Movement; Zombies, Revenants, Vampires, and Reanimated Corpses

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Necrophilia

Necrophilia refers to engaging in sexual intercourse with a corpse. This behavior has been referred to as a dangerous sex crime, regardless of the physical state of the victim before the act of necrophilia. The necrophile may mutilate a corpse before, during, and/or after the sexual encounter, or may simply sexually assault the corpse. In some instances, the perpetrator actually commits a murderous act and then performs an act of necrophilia upon the corpse. The necrophile is typically an individual who becomes sexually excited and aroused by viewing a dead body or simply going to a funeral home or cemetery, and who then needs or relies on the dead body to fulfill the sexual gratification.

Most individuals view the act of necrophilia as immoral and heinous, and the individual who performs an act of necrophilia as mentally deficient, having an abnormal and perverse sensuality. Although it is difficult for most people to accept that any individual could engage in this type of behavior without some type of mental abnormality, the behavior develops out of an erotic attraction to dead bodies emerging from the need to gain control by engaging with a partner who is unable to resist.

The typical necrophile is male and the typical victim is female, although a few female necrophiles, such as Karen Greenlee and Leilah Wendell, have been identified in recent years. Victims are generally viewed, by the necrophile, as substitutes for the women who have rejected him, so he resorts to corpses to stimulate and facilitate the act of masturbation. Sexual gratification, therefore, is

achieved through the engagement of sexual activities with a dead body. Although many necrophiles can and do engage in consenting sexual relationships, many with spouses, the most desired and powerful sex is with a corpse.

Necrophilia as a sexual act is not a new phenomenon. Evidence indicates that ancient people, including Egyptian, Roman, and Greek men, practiced the act of necrophilia. For example, in ancient Egypt, precautions were taken to ensure that the corpses of the wives of men of rank were not violated by the embalmers. It is also known that government agencies attempted to thwart this activity by placing guards to protect the gravesites of royalty from grave robbers and sexual predators. In the late 20th century, necrophilia became more recognized in the United States and elsewhere, as stories of serial killers having sex with their dead victims became headline news.

The American public seems fascinated with stories of murder and sex. Indeed, the lives of Ted Bundy and Jeffery Dahmer became not only front-page news, but also "movies of the week" on various cable movie networks. But these stories are not limited to the United States. Serial killers and necrophiles Dennis Nilson in London and Andrei Chikatilo in Russia, known as the "Rostov Ripper," made headlines across the world. In 2006, police in New Delhi, India, identified Surendra Koli as a serial killer, with some labeling him a necrophilic predator.

Currently, there is no federal legislation barring the engagement of sex with a corpse. However, at least 17 states have enacted statutes making the act of necrophilia a crime. About half of the states have made the act of necrophilia a felony, carrying a sentence of up to 10 years in prison.

Types of Necrophiles

Three types of necrophiles have been identified. The first is identified as the pseudonecrophile—an individual who has a transient attraction to a corpse and only fantasizes about sexual activities with a corpse. The partner of the pseudonecrophile is alive and well but cooperates in a sexual encounter that requires her to pretend to be dead. The sexual encounter is made possible when the woman takes a cold bath or shower, dusts with white powder, then lies completely still in bed or even in a coffin while the man performs sexual acts. It is of paramount importance that the female remain absolutely still, as any movement on her part, however slight, will cause the necrophile to withdraw. Should this occur, his ability to engage in the sexual act will decrease or disappear completely. Two closely related types of pseudonecrophile are the necrophile fantasy offender who, while he fantasizes about having sexual relations with a corpse, does not carry out these fantasies. The platonic necrophile, on the other hand, does not actually touch a dead body; rather pleasure and sexual gratification is gained merely from viewing the body.

The second type of necrophile is an individual identified as a regular necrophile. This individual engages in sexual activities with a person who is already dead. This individual is able to carry out his necrophile tendencies by placing himself in an occupational setting that allows for easy access to individuals who have already died. For example, the regular necrophile may be employed as a morgue assistant, funeral parlor assistant, ambulance driver, hospital orderly, cemetery employee, or assistant in a coroner's office. Gaining easy access to corpses allows the fantasy that demands sexual activity with a corpse to be easily realized. This is the most common type of necrophilia, as most necrophiles obtain bodies through their work.

A third type of necrophile is identified as a necrosadistic offender. Also known as a homicidal necrophile, the necrosadist murders his victims for the sole purpose of engaging in sexual relations with the corpse. Mutilation of the corpse often occurs; the mutilation apparently is seen as an important part of the event/ritual, as this act is thought to reduce the worth of the corpse while increasing the emotional excitement of the necrophile. The ultimate gain for this type of necrophile is the sexual gratification gained from the encounter with the corpse, not the act of murder. Although this type of necrophile is considered by most analysts to be extremely rare, examples of the necrosadist or homicidal necrophile can be found in historical as well as in recent literature, including the chronicles of Ted Bundy, John Wayne Gacy, and Albert Fish.

Characteristics of the Necrophiliac

The etiology of a necrophile is not easily identified. What serves as identifiable characteristics of a necrophile suggests differing levels of participation in

acts of necrophilia, from merely fantasizing about a sexual relationship with a corpse (the most common), to engaging in a sexual relationship with a corpse, as well as the act of murder for the purpose of obtaining a corpse for sexual gratification. Because the participation level ranges through the extremes of human behavior, the explanations are also diverse, ranging from explanations for why an individual who fantasizes and does not carry out the necrophilia act is different than another individual who wishes for a necrophilia encounter and is willing to commit murder to fulfill these desires.

Although a wide range of personality characteristics of necrophiles has been identified, many of these characterizations are inconsistent. Thus, it is extremely difficult to establish a checklist of personality characteristics for the necrophile. As a case in point, some necrophiles have been identified as heterosexual, while others are identified as homosexual. Many necrophiles indicate they engage in non-necrophile intercourse, indicating part-time perversion and part-time conforming sexual behaviors and activities. And necrophiles also have been identified as having histories of previous sadistic sexual activities. Necrophiles have been diagnosed with personality disorder and/or engaging in behavior considered by some evaluators as psychotic. But most if not all necrophiles are of above average intelligence and have normal personalities.

Necrophiles are known to engage in other forms of dangerous and unusual behaviors, including vampirism and cannibalism. The true vampire practices necrophilia, while the autovampire fantasizes about having a dead body, and is thus classified as a pseudonecrophile. Moreover, many necrophiles engage in necrophagia or the cannibalism of a corpse.

Explanations for why an individual would engage in an act of necrophilia vary as much as the explanations offered by the researchers who attempt to explain the act. Necrophiles have been identified as insensitive to others, possessing a deep hatred for women, and experience an overwhelming fear of rejection. In the latter instance, the perpetrator compensates for feelings of inadequacy inasmuch as the actual sexual activity with a corpse provides the necrophile with sense of having the victim in complete submission to his authority and will. Rejection does not happen, failure does not occur, and humiliation is impossible.

Total control of the sexual encounter and total domination over the victim appear to be among the general characteristics of all necrophiles. In addition, alcohol abuse is reported as an important factor. However, for the homicidal necrophile, alcohol may actually assist in vanquishing trepidations about killing rather than enhancing the necrophilic act. Other motivations identified include an attempt to overcome feelings of isolation and the need for comfort, being reunited with a romantic partner, having a conscious sexual attraction to corpses, and improving self-esteem. All seem to be enhanced through exerting control and power over a homicide victim.

Finally, paraphilia, defined as an erotosexual condition to which a person is recurrently responsive to and obsessively dependent upon, is noteworthy in relation to necrophilia. Paraphilia is also characterized by arousal from an unusual or unacceptable stimulus, perception, or fantasy. For individuals diagnosed with paraphilia, the stimulus is necessary to initiate or maintain erotic arousal and to achieve or facilitate orgasm. It is known that necrophilia may occur in conjunction with other paraphilias. This is important and relevant to any treatment options for necrophiles, including medications to reduce sex drive and improving social and sexual relationships.

Deborah Mitchell Robinson

See also Cannibalism; Grave Robbing; Serial Murder; Sex and Death; Sexual Homicide

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Neomort

A term coined by Willard Gaylin in a 1974 *Harper's Magazine* article, neomort refers to an individual human who has suffered brain death but whose other biological capacities have been maintained on a respirator, possibly with cardiac assist. This entry explores the issues surrounding the potential use of neomorts as organ donors and for other purposes.

The traditional criterion of death had been irreversible cardiac arrest. So defined, death was compatible with the transplantation of certain organs, including kidneys and corneas. But the growing practice of cardiac transplantation rendered the traditional criterion no longer useful. In the past, cardiac transplantation involved the removal of the still-beating heart from one individual and the implantation of it into the body of another individual suffering from heart failure. If irreversible cardiac arrest were to remain the definition of death, cardiac transplantation would forever be an act of killing the donor. The plight of individuals suffering from failing hearts who could have their normal lives restored through cardiac transplantation prompted the redefinition of death in the 1960s.

Redefinition was necessary, for heart transplants must be made with the living heart, unlike other organs. This meant removing the beating heart from the donor and transplanting it into the receiving patient. Doing so, under the cardiac criterion of death, entailed killing the donor even if no brain function was present.

Legislation was developed to redefine death. In a remarkable show of unification, all 50 states passed the same legislation in short order. The model that "brain death" proponents advocated, now adopted in all 50 states, is the Uniform Determination of Death Act (UDDA) of 1986, Section 1, chapter 23-06-01. Effective as of July 1, 1987, this act reads as follows:

> An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

That widespread acceptance, however, did not signal an absence of criticism. First, based on various apocryphal accounts of individuals who, having been declared dead, revive, many have doubted that diagnosis of brain death that leads to cardiac transplantation is an unerring procedure. One critic likened it to execution of individuals later found, through DNA analysis, to be innocent of the crimes for which they were convicted.

Second, there was suspicion of the motives of those who advocated the brain death criterion over a previous "dead donor rule," the permanent cessation of the functions of the prospective donor's heart. Despite a wide public support for increasing organ supplies, critics argued that elevating this laudable goal over the satisfaction of the then current criterion of death was an act that elevated pragmatic utility over our commitment to fight to preserve one another.

Third, the clamor for access to transplantable organs of patients suddenly confronted with the consequences of personal irresponsibility plus the indifference to prevention of a public health policy oriented toward cure rather than prevention, together with the financial rewards to transplant hospitals of such surgeries, places the dying in the service of the salvageable.

Against all these objections, the new definition of death was legally and widely accepted. Nonetheless, a host of other troubling issues stood in the wings awaiting their consideration.

First, a choice needed to be made between requiring prior explicit consent of the prospective donor to the harvesting of organs, and presuming the donor's consent absent an indication by the donor to the contrary. Numerous other countries have a policy of routine retrieval of transplantable organs from cadavers and neomorts, grounded on a supposed inherent obligation of the individual to the society. The United States could follow this philosophical orientation to maximize the supply of transplantable organs, or it could require explicit consent from the competent donor, expressed through a public verbal wish, a signed and current donor card, or a conversation with a loved one or health care professional, in prospect of a looming demise.

While routine retrieval was rejected in the United States in place of prior consent, the threat of possible litigation prevents its complete effectiveness. Even with a signed and witnessed donor card, transplant units in hospitals are unwilling to

honor donors' expressed wishes in the face of the disagreement of any next of kin.

One suggestion is to permit procuring organs during the terminally ill patient's dying phase after informed consent has been obtained. Such autonomy-based end of life donations raise the issue of coercion in the process of obtaining and acting on consent to donation, but the issues there are not substantially different than those successfully dealt with in Oregon's procedures that permit terminally ill patients to obtain a physician's assistance in hastening death.

Gaylin's *Harper's Magazine* article suggested other possibilities offered by neomorts that highlight the need for extensive public discourse. In his novel *Coma,* physician-author Robin Cook envisioned neomortuaries, in which neomorts would be maintained on life support and used for various medical and scientific purposes. Gaylin suggests other possible uses for neomorts: training of medical students ranging from routine medical exams to practicing surgical techniques; testing of drugs and surgical procedures to decrease the likelihood of species-specific incompatibilities that might steer us away from promising therapies or toward therapies with negative effects that were not predictable based on animal experimentation and the reporting of cellular data alone; banking of organs and tissues, thoroughly typed and cataloged, to be held available for the transplantation needs of future patients; continual harvesting of renewable and multiply present tissues throughout the body; and manufacturing of hormones, antitoxins, and antibodies.

The prospect of viewing each of us as standing to the other as potential source of life extension is disturbing. Yet, for some, the prospect of a kind of life extension in service of others after our death is attractive.

Richard T. Hull

See also Brain Death; Defining and Conceptualizing Death; Informed Consent; Organ and Tissue Donation and Transplantation; Persistent Vegetative State; Terminal Illness and Imminent Death

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Neonatal Deaths

A neonatal death is death of an infant prior to the 28th day of life. Demographers and epidemiologists define the neonatal mortality rate (NMR) as:

$$NMR = \left(\frac{Deaths^{z}_{<28days}}{Births^{z}} \right) * 1{,}000,$$

where

$Deaths^{z}_{<28days}$ refers to deaths to infants younger than 28 days old, in year z; and

$Births^{z}$ is the number of live births in year z.

Neonatal deaths are usually examined separately from other infant deaths occurring during the first year of life. This distinction is made because (a) there is very high mortality during the first minutes, hours, days, and weeks of life, and (b) the causes of death in the neonatal period tend to differ from the causes in the postneonatal period (28 days to 364 days after birth).

Primary Causes of Neonatal Mortality

In 2005, about 30% of all neonatal deaths occurring in the United States were due to prematurity, or being born before 37 weeks of gestation. Generally, the more premature the infant, the more likely death will occur. Only about 20% to 35% of babies born at 23 weeks of pregnancy survive, compared to 50% to 70% of those born at 24 to 25 weeks. Survival increases to more than 90% at 26 to 27 weeks' gestation, whereas births before 32 weeks' gestation, comprising about 2% of all births, account for most neonatal deaths and disorders.

Premature births occur after spontaneous premature labor (50% of cases), a spontaneous rupture of the membranes (30% of cases), and intentional

delivery of a premature infant for the benefit of the infant and/or mother (20% of cases). Causes of preterm birth that are the consequences of the mother's health include high blood pressure, placental problems, a previous preterm delivery, a multiple birth, and abnormalities in the uterus or cervix.

Neonatal deaths also result from structural and genetic birth defects such as spina bifida, anencephaly, and heart or kidney defects. Birth defects account for around 21% of all deaths to infants in the United States recorded during 2005. Defects where the heart and lungs do not develop fully are the most common cause of neonatal death. Abnormalities in which the infant has more or less than the normal 46 chromosomes represent a common cause of neonatal death. It is rare for embryos with chromosomal abnormalities to survive the pregnancy, but those who do will likely die within the first few weeks of life. Other less prominent causes that account for the almost 40% of remaining neonatal deaths include pregnancy related problems, such as complications involving the placenta or problems with the umbilical cord and membranes.

Variation in Neonatal Mortality

Every year four million infant deaths occur during the neonatal period. Globally, 99% of neonatal deaths are in low- or middle-income countries. The largest numbers of neonatal deaths occur in south-central Asian countries with the highest rates in sub-Saharan Africa. Worldwide, the main cause of neonatal deaths is preterm birth (28%), severe infections (26%), and asphyxia (23%).

In developed countries, around two-thirds of all infant deaths occur during the neonatal period and are often due to preterm delivery or birth defects. There has been a dramatic decline in the NMR due to low birth weight mortality, whereby almost 80% of the deaths are to birth weights of less than 750 grams. This decline is believed to be due to technical strides in obstetrics, neonatal intensive care, and policies that provide health care access to disadvantaged groups.

The NMR in the United States has fallen from 15.1 in 1970 to 4.62 in 2003. However, global neonatal mortality numbers have not significantly changed. Even though infant mortality rates continue to decrease because of widespread interventions that include vaccines and oral rehydration therapy, the proportion of neonatal deaths is likely to increase because 98% of deaths, largely due to infections (32%), occur in the poorest countries where many births occur outside of the formal health care system.

Distribution of Neonatal and Postneonatal Deaths

In developed countries, the risk of infant death is higher in the days immediately following birth and then diminishes. In contrast, the risk of infant death in developing countries increases with age. Thus, developed countries tend to have a higher percentage of all infant deaths in the neonatal period, whereas developing countries have a higher percentage of all infant deaths in the postneonatal period.

The world NMR is 30, with Africa and Asia having the highest rates at 41 and 32 respectively. Europe and North America record the lowest rates, both at 5. The postneonatal mortality rate for the world equals 47, with the highest rates recorded in Africa and Asia at 62 and 50 respectively. The 2 lowest postneonatal mortality rates are in North America at 7 and Europe at 13.

The countries with the highest NMR in 2004 were Liberia (66), Cote d'Ivoire (64), Iraq (63), Afghanistan (60), Sierra Leone (56), Angola and Mali (54), Pakistan (53), and Central African Republic and Lesotho (52). Countries with the lowest NMR were Singapore, Japan, and Iceland (1), Sweden, Spain, Slovenia, San Marino, Norway, Monaco, France, Finland, Czech Republic, Cyprus, Belgium, and Andorra (2). The United States had an NMR of 4.

However, it may be incorrect to compare mortality rates across countries because countries often define births and, therefore, infant deaths differently. For example, in Austria and Germany, birth weight must be at least 500 grams to be considered a live birth. In other parts of Europe, the fetus must be at least 30 centimeters long. In Belgium and France, births resulting from less than 26 weeks of pregnancy are automatically registered as lifeless; and some countries do not register babies who die within the first 24 hours.

Dudley L. Poston Jr., Bethany S. DeSalvo, and Rachel Traut Cortes

See also Death Certificate; Infanticide; Infant Mortality; Miscarriage and Stillbirth; Neonaticide; Sudden Infant Death Syndrome (SIDS)

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Neonaticide

In 1969, Phillip Resnick documented the killing of newborns within 24 hours of their births as a unique form of infanticide, describing the crime as neonaticide. Though relatively uncommon in the contemporary experience, neonaticide typically follows concealed pregnancies that are discovered when the bodies are found, for example, in trash receptacles. Neonaticide is often the result of a new mother's efforts to hide or dispose of a live-born infant to prevent discovery of the pregnancy and birth by her parents. Neonaticides also arise when a victim's mother seeks medical attention for complications from an unassisted delivery, but disavows having given birth. The aftermath of a brief search for her child is discovery of her newborn's untimely death. Neonaticides differ from the killing of older infants and children in terms of motive, method of killing, and offender demographics.

Those who commit neonaticide tend to be young, unmarried women in their teens or early twenties. They are typically terrified of their parents' reactions to nonmarital pregnancy, fearing that their parents will banish them from their home or they will lose their parents' love and/or respect. Some also worry about the shame surrounding illegitimate births, that their futures will be negatively affected by parenting an illegitimate child, or that their paramours will desert them if they divulge their pregnancy. These women postpone disclosure, but seldom know when their babies are due and panic when labor takes them by surprise. During chaotic, unsupervised births, the hysterical mothers may harm or dispatch their newborns. Some women remain in denial about their pregnancy until close to their delivery dates and a few remain in denial even after delivering their newborns and allowing them to die in confusion-filled deliveries, complicating classification of their intentions. A few women plan to deliver then kill their newborns, but these cases are quite rare. Instead, it appears that the vast majority of newborns are killed by young mothers who are overwhelmed by the prospects of pregnancy and parenting, and who panic during delivery.

Historical Efforts to Control Neonaticide

Attempts to address the problem of neonaticide have occurred since at least 318 C.E., when Emperor Constantine outlawed the then common practice of Roman fathers killing unwanted infants under *patria potestas*. Other attempted solutions included foundling homes where families could deposit unwanted newborns, some of which were outfitted with devices that allowed for anonymous surrenders of unwelcome children. Proclamations of religious edicts and regulations were issued from many a church pulpit, but these did little to eradicate the gruesome discoveries of discarded newborns. When social and religious responses failed to work, laws were enacted to address increases in the incidence of neonaticide.

The most important law was the 1624 Act to Prevent the Destroying and Murdering of Bastard Children, which held that women who concealed their illegitimate pregnancies were to be executed if their children were found dead, even if they claimed their children were stillborn in an unassisted birth.

This British law specifically addressed the common defense at the time, that newborns discovered by authorities had simply been born dead. It also served as the basis for other nations' legal reforms, and versions of the law spread throughout Europe and into the fledgling U.S. colonies. The laws did not eliminate the killing of newborns, however, and neonaticides continued to constitute a sizable percent of homicides in Europe and the United States. Over time, public sentiment softened toward neonaticidal women and juries refused to convict based on their desire to avoid draconian penalties for pitiable defendants. The laws were then amended so that proof of intent is required.

Incidence of Neonaticide

Despite the intense media coverage that often surrounds neonaticide, documented instances of the crime are relatively uncommon in the United States. According to official statistics, the number of newborn deaths attributed to homicide averaged 25 per year from 2000 to 2005, ranging between 23 and 31 deaths per year. Before reliable birth control and access to legal abortions, the numbers were several times higher, averaging 69 neonaticides per year from 1943 (the first year reliable data on neonaticides were collated) and 1973 (the year access to legal abortions was guaranteed). The numbers have averaged 26 neonaticides per year since 1973. It is important to note, however, that these statistics do not include undetected neonaticides, which could number into the thousands according some scholars.

The typical neonaticide victim is killed through neglect or passive means rather than intentional homicide. One-third of the documented neonaticides between 2000 and 2005, for example, resulted from suffocation of the victim and another 14% were due to drowning. Victims may drown when their mothers deliver into toilets or be suffocated during misguided attempts by their mothers to silence their cries. Only 5% of the killings between 2000 and 2005 involved weapons. The other neonaticides resulted from fatal falls during delivery, exposure, or other unspecified causes.

Although female neonaticide is thought to be a problem in some countries, neither gender is more likely to be the victim in the United States. Nearly identical percentages of documented neonaticides between the years of 2000 and 2005 were males and females (49% vs. 51%). With respect to race, most neonaticide victims are white. Two-thirds of neonaticide victims between 2000 and 2005 were white, 30% were black, and 8% were other races.

Jon'a F. Meyer

See also Abortion; Angel Makers; Childhood, Children, and Death; Homicide; Infanticide

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Obituaries, Death Notices, and Necrology

Death is the final equalizer, but how the living interpret and respond to death and how it is presented publicly is social and cultural. Some form of public notification of individual death is common in all of the developed world and much of the underdeveloped world except in times of mass tragedies, such as war, famine, or natural disaster. The form of death notification depends largely on location in time and place of the deceased and on the social meaning of death in a particular culture and time.

There are different labels for the public notification of death; obituary, derived from the medieval Latin *obituārius,* "report of death," is perhaps the most common. Obituaries and death and necrology notices are all a means of communicating to the public, usually to selected audiences, that one among us has died. Published obituaries or death notices typically include minimal vital statistics, and some provide more personal information that further identifies the deceased and describes what kind of person he or she was. Today in the United States, almost all deaths receive some publication closely approximating the actual statistics of death.

Progress toward the egalitarian obituary, however, is yet to be realized in most cultures. Mushira Eid commented that when she began researching obituaries in the Egyptian press in the 1930s she found "a society without women." Until the late 20th century, not only in Egypt but also in the United States and many other countries, women were identified in their obituaries by their husbands or fathers, not for their own lives and often not even by their own names. Janice Hume noted the absence of women, children, African Americans, and of the poor and powerless in general from obituary pages in 19th-century America. Another example of how obituaries, or the lack thereof, reflect social status is the case of slaves whose deaths were noted only by family and by word of mouth.

Well past the time of slavery there was infrequent public notification of African American deaths, and many were buried in unmarked graves. If their passing was noted, it was because of their relationship with prestigious whites or because they were presented as role models for their race. For example, a "colored woman" was remembered in the *Baltimore Sun* in 1855 for "her loyalty to her mistress." Historically, the changing status of African Americans in the United States can be gauged by their representation in mainstream media obituaries. The current use of obituaries to announce deaths for those of all stations in life is a result of accessibility and affordability of print and, more recently, electronic media and an underlying ideal about the worth of all people bolstered by the growth of the funeral industry.

Necrologies

Another means of notifying the public of selected deaths is that of a necrology. Before the printing press made daily publication and mass dissemination of information possible, it was customary for publications to periodically disseminate lists, a

necrology, of people who had died in a given time frame. Many organizations or publications continue the practice of collecting and disseminating the names and perhaps a brief biography of people who died over the past year, since the last meeting or last publication. The necrology may be selective, as in well-known actors or public personalities, or limited to members of a particular group, such as a church or fraternal or professional organization. Less selective necrologies can simply include all people known to have died in the past year, by community or state. The practice of gathering and listing deaths of relevance to a particular audience is an old one, perhaps first practiced as early as 1731 by *The Gentleman's Magazine* of London. In 1869, the London *Times'* necrology for the year listed deaths in order of precedence: members of the House of Lords, followed by those of baronets, then those from the arts and sciences, the legal world, the professional army, and the House of Commons.

Function of Death Announcements

The announcement of death, whether labeled obituary or death or funeral notice, is a cultural artifact with variations determined by history, custom, religion, social class, gender, technology, the news media, and publishing policy. Public announcements of individual deaths, today largely products of the print news media, serve multiple functions in any given culture. Obituaries are important data for genealogical, sociological, and anthropological researchers. They can help the researcher piece together individual or family biographies, and they can inform about historical or cultural eras in the life of a community or society. For social scientists interested in documenting social-structural changes, obituaries are microlevel reflections of macrolevel realities. For survivors, obituaries are a part of the process of grief management, informing the public about a death and often including content for the purpose of impression management. Many obituaries serve as a tribute to the deceased and to his or her life accomplishments and community service; therefore, they present positive, selective facts. News obituaries, typically written by journalists about well-known people either in the national or local arena, in addition to announcing the death of a public figure, have historical significance and serve as a kind of collective memory. Local obituaries register the deaths of ordinary citizens as a public service, and national or international publications register the deaths of the famous, infamous, and the powerful. In recent years, particularly in capitalistic societies, obituaries have taken on an economic function. Many newspapers charge for printing obituaries or charge beyond a minimum number of lines. Families will typically pay for long announcements or to have a picture printed because these artifacts are a means of distributing grief and of showing respect for the deceased. Politicians and business and professional people regularly read (or have someone read for them) obituaries in local papers to learn who among their constituents, clients, customers, or the significant others of any of these, has died. In response, they will send flowers or other condolences. For some newspapers the daily obituaries are a source of revenue. For the reading public, they are an integral and important part of their newspaper.

Democratization of Obituaries

Obituaries of celebrities or public figures, known as news obituaries, appear in newspapers with national or international readership and represent a kind of cumulative history. Such obituaries are selectively written in publications once called newspapers of record, for example, *The New York Times, The Washington Post, The Times* of London, and *Le Monde* of Paris, among others. This is true of the obituaries of ordinary people selected as newsworthy by local papers. They not only pay tribute to individuals but also are representative of a community or historic era (for example, the last civil war veteran). News obituaries written by journalists, whether local or international, have a different historical significance than those written by family members, which are often more about family survivors than the deceased.

Until relatively recent times, obituaries were indicative of social status. It was not until the late 20th century that obituaries underwent a type of democratization, giving every citizen some, even minimal, publication of death. It is also a relatively recent phenomenon that information deemed socially inappropriate is not screened out of obituaries, for example, when the cause of death was

suicide or AIDS. Divorces were deleted from life histories, as were illegitimate surviving children or nonmarital partners. It was newsworthy in the 1990s when *The New York Times* began identifying deaths caused by AIDS and when papers began identifying surviving partners, including same-sex partners. Today, even those of ignoble reputation may be eulogized in an obituary if he or she is deemed newsworthy. However, the democratization of death is still incomplete; there is still an uneven quality in publications. Those deemed worthy of news obituaries still tend to be the dominant male group in any culture.

Public Announcement of Death

There are various means of announcing the death of an individual, some simple and factual, others elaborate and socially constructed. Public announcements of death have evolved from the days when the town crier or the "Death Crier" marched through the village streets, often with bell in hand, informing all within hearing distance of the latest death or deaths. Later this verbal announcement was replaced by publicly posted notices. Today death notices, obituaries, and necrology reports are recognized as a part of the publication of death; however, it is impossible to provide a uniform definition of the first two. There is a tendency on the part of the public to use the terms death notices and obituaries interchangeably, with these being differentiated largely by working definitions in some publications. Daily newspapers often differentiate the two, but some reverse the definitions of death notice and obituary, typically differentiated by free versus paid newsprint. The news obituary, however, is more clearly differentiated by the fact that it is a news story about the death of a person significant to a readership audience. The simplest, most direct, and most similar of the three phenomena, termed by some a death notice and by others an obituary, conveys the basic facts about a life and death: name, time of death, date of birth or age, and funeral information. Such brief notices of death are symbolic equalizers, as they include no superfluous information, no clues as to whether this was an important person or an individual known only to family and friends. Such limited notifications of death are little more than vital statistics, typically generated by mortuaries, and published free of charge by most newspapers, now both in print and online. These brief notices may or may not be followed by a longer obituary, usually written by a family member, friend, or sometimes by the deceased. The longer obituaries are typically transmitted to the news media by a mortuary or crematorium and are more likely than the abbreviated notice to contain information written to present the deceased in a select and positive way. Long obituaries also contain facts as to lineage, spouse or life partner, and progeny of the deceased. They often eulogize the deceased and provide markers of his or her accomplishments, memberships, and honors. The more detailed notifications of death are generally published as paid announcements; some newspapers handle them through their advertising departments. Thus, in death a person's obituary is socially constructed and cost accounted. When the brief, free death notice is not followed by a more personal and in-depth memorial to the deceased, it is usually for lack of family or because the deceased died in institutional care or outlived others who would be interested in their passing. Some journalists have expressed concern that many papers routinely run uncensored family-paid obituaries alongside the minimum-line free announcements with no differentiation, leaving readers to wonder why some people get more space and more accolades than others. There is little question, however, that the longer versions of death notice are more interesting, from both a cultural and a research perspective, than the vital statistics form.

Paid Obituaries

Publishing policy regarding death notices/obituaries is the subject of much debate by journalists, editors, and the public at large. Most newspapers have a clear policy about what they will publish and the cost. A survey by the Readership Institute found that most papers provide both free news obituaries and paid obituaries with the length and detail in the news obituary varying from the barest essential facts to expansive chronicles of the deceased. Although most newspapers have shifted the function of the in-depth obituary to a paid obits feature, they continue to offer a free minimum-line death notice so every passing life is noted, even if

the family cannot afford or chooses not to buy a longer obituary. The fact that most newspapers, both local and national, have implemented a paid obituary policy is justified by some because print and online venues are now provided. In fact, some newspapers allow family or friends to write obituaries online and the public to write messages of condolences or personal anecdotes about the deceased. However, paid obituaries remain controversial, as evident in an editorial in *The American Journalism Review,* charging newspapers with relinquishing their public responsibility by implementing paid obituaries and treating the death of a community member as a commercial venture.

The fact is that many survivors, especially family members, will pay for an announcement (some sacrifice to do so), even as the news media continue to commercialize obituaries and death announcements. Not every newspaper will provide a cost-free news obituary for every ordinary citizen. Survivors, however, need to publish the death of their family member or friend as a request for the public to share in the grief and appreciate the life of a unique individual. Notifications of death are found in the Obituaries page of any local newspaper on any given day, usually produced by family, friends, or morticians. These typical publications will contrast sharply with those professionally written (perhaps in advance of death) to mark the passing of a much loved or renowned public figure. In both cases, however, public notification is a part of the social response to death. As death is published, grief is distributed and the private pain is shared.

Joyce E. Williams

See also Death, Sociological Perspectives; Death Notification Process; Eulogy; Gender and Death; Language of Death; Life Review; Social Class and Death

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Organ and Tissue Donation and Transplantation

The transplantation of organs is a well-established therapeutic intervention and part and parcel of specialized surgical services in many hospitals all over the world. Organ transplantation entails the surgical replacement of irreparably damaged organs with healthy ones obtained from either living or deceased human or animal sources.

The number of organ transplants around the world is estimated at about 80,000 per year. Survival rates can vary significantly depending on many factors, such as the condition of the organ to implant, organ and receiver compatibility, the health status of the recipient, and so forth. Under satisfactory medical conditions, the rate of successful organ replacements is quite high. For example, survival rates for a patient after heart replacement surgery in the Cedars-Sinai Medical Center, Los Angeles, California, are more than 90% survival after 1 year and more than 80% after 3 years. The survival figures for patients after a kidney transplant is on average 97% after one year and 94% after 3 years; for transplantation of the liver, patient survival is 85% after one year and 80% after 3 years; and for pancreas transplantation it is 97% after 1 year and 90% after 3 years. The rate of survival for bone marrow transplantation with donated bone marrow is 73% after 1 year.

History

The first successful organ transplantation took place in 1954 after a number of years of failed

attempts. A kidney transplant was performed at the Peter Bent Brigham Hospital, Boston, Massachusetts, where donor and receiver were identical twin brothers. The recipient lived for 25 years with the transplant. However, for genetically unrelated patients the results were less promising due to the recipient's immune system rejecting the "foreign" organ. Successive trials underscored the importance of a good blood and tissue compatibility between donor and receiver in order to avoid organ rejection. Compatibility guidelines were established and issued.

A major breakthrough in the avoidance of organ rejection was the development of immunosuppression drugs: cyclosporine in 1972 and tacrolimus in 1987. This made possible the transplantation from organs other than kidneys or hearts and the transplant of tissue from living donors, such as bone marrow, with good long-term results.

The Transplantation Process

Cadaveric Organ Donation

A major source of organs for transplantation is deceased people. The most common transplantations are of kidneys, heart, lungs, liver, pancreas, corneas, and also of parts of the intestine.

A transplantation can be divided in two phases, first the extraction of the organ from the donor body and, next, the reinsertion of the organ into the body of the recipient. The lapse of time between the organ extraction and the transplantation of the organ into the patient is of utmost importance because the longer the organ is outside of the body without blood circulation and oxygenation (i.e., ischemic time) the more the organ deteriorates. A heart, for example, extracted from the donor's body, even when kept in appropriate ice-cold fluids, cannot be maintained more than 4 hours. Kidneys can be maintained for up to 36 hours.

The organs are extracted from recently deceased donors or more commonly from brain-dead donors. Brain-dead donors are deceased by reason of their brain and brainstem function being irreversibly damaged (i.e., irreversible loss of consciousness, lack of autonomous respiration and reflexes), but whose blood circulation and respiratory function are artificially sustained.

Organ donors must be relatively young and free from any systemic disease, such as cancer, infections, or transmissible diseases, that could infect the receivers. Comparatively few potential donors qualify. Ideal candidates are healthy, brain-dead donors that are dead as result of, for instance, head traumas, whose bodies are kept artificially ventilated (oxygenated) and blood circulation artificially maintained so the organs stay in optimal condition until the transplantation is to take place.

Once a deceased is assessed as a potential donor in the intensive care or emergency unit of a hospital, a nurse, physician, or personnel of a local organ procurement agency (OPO) will contact the relatives to assess the views of the deceased as well as his or her family regarding a possible organ donation. If the answer is affirmative, information is sent to the regional transplantation center, where a transplantation coordinator will instruct the personnel at the local hospital on how to care for the donor body or organs, and at the same time order the laboratory tests needed to determine the status of the organs, blood and tissue type, and so forth. The transplantation coordinator will also be responsible for choosing a suitable patient from the organ waiting list. A good match between organ and patient is a relevant factor in achieving a successful transplantation even if the developments in immunosuppression (i.e., antirejection therapies) have made it less critical than years ago.

The Organ Transplantation

The success of a transplantation largely depends on the organ and the recipient being as compatible as possible; that is, the blood group and antigens (rejection markers in white cells) of the organ and of the recipient will have to "match" in order to reduce the rejection of the alien organ by the recipient's immunity system. Except in organ donation between genetically identical twins, the risk of rejection of the transplanted organ will be a lifelong affair, and the recipient will need to take antirejection drugs on a permanent basis.

Patients in need of organ replacement are enlisted by their physicians in the corresponding organ waiting list at the local transplantation center. Patients are ranked according to several relevant factors: degree of urgency, time waited thus far on the list, distance to transport the organ, and health status of the patient. Selection among those ranked high on a list will ultimately depend on the degree of blood and tissue compatibility with the available organ(s). Some organs are so scarce, such as children's hearts,

or the patient on the waiting list is so "mismatched" by having for example an unusual blood type, that the coordinator will search into national and even international lists for an appropriate match.

The relatively few deceased who qualify as appropriate organ donors, along with the increasing number of serious conditions that can be successfully treated with organ replacement, makes human organs critical resources. As a result and because organ markets are banned in most countries, organ scarcity has led to the design of complex structures of organ distribution and sharing to ensure that most waiting patients will get a fair chance of receiving an organ.

Living Donation

Organs, commonly a kidney or parts of the liver, can also be obtained from living donors, often blood relatives (i.e., genetically related) and therefore compatible donors. The donation of a kidney and liver parts are possible because the donor can go on living with the remaining kidney, and the liver regenerates, even though there are some risks involved in the removal of the kidney or liver section and future complications. Living organ donation from genetically unrelated donors, such as spouses and friends, are also performed with comparable rates of success. Living donation among relatives can entail ethical problems in connection with familial obligations, social pressures to donate, and even the use of indirect forms of payment. Similarly, transplantation with organs from a genetically unrelated donor can entail forms of payment and money exchange that the hospital has little possibility of controlling.

Tissue transplantation is understood as the transplantation of stem cells from the bone marrow. Stem cells are unspecialized cells that have the capacity to develop into more specialized types of cells. Bone marrow transplants are used in the treatment of several blood diseases, such as leukemia and lymphoma. The aim of the procedure is to replace the damaged bone marrow of the patient with healthy stem cells after the patient has undergone radiotherapy and chemotherapy.

There are two major types of bone marrow transplants: autologous and allogeneic. In the autologous type, the patient's own stem cells in the bone marrow will be extracted before the chemotherapy or radiotherapy and then reintroduced afterward. The reason is that chemotherapy destroys not just cancer cells but also stem cells, leaving the patient without defenses to resist infections.

In the allogeneic type, the blood-forming stem cells injected in the patient after chemotherapy are transplanted from a genetically compatible donor (e.g., a genetically compatible sibling). National and international bone marrow donation programs and registries have been developed in order to find compatible stem cell donors for patients in need of bone marrow transplants and who do not have compatible related donors.

Models of Cadaveric Organ Donation

Most countries have regulations concerning the use of human organs and tissues for therapeutic purposes. Existing regulations concerning cadaveric organ donation are based on two donation models. In the "opt-in" model, organs are obtained from individuals who, when they were alive, made an explicit statement to donate (relatives may donate the organs following the wishes of the deceased). In the "opt-out" model, organs are obtained from all deceased individuals who fit the organ donor profile, except from those who, when they were alive, vetoed the donation (relatives may also veto the donation following the wishes of the deceased). The first type of policy underscores donation as an act of giving, while the second type underscores the responsibility of the collective toward patients in need of organs. Notwithstanding the policy, with the exception of Spain and Finland, the rates of organ donation are endemically low in most countries, even if variation is found due to sociocultural characteristics (e.g., Hispanics in the United States are less willing to donate) and gender (males more willing to make cadaveric donations). Also, while a few religious groups forbid organ donation, most large religions approve the procedure.

The low figures of organ donation are just one of the factors explaining organ scarcity. Advances in neurosurgery and emergency medicine have reduced the number of potential organ donors from accidents or trauma to the brain, so the hope of increasing the number of organs focuses on the increasing use of non-brain-dead donors (e.g., patients dying in emergency units), xenotransplants, and even organ markets.

Ethical and Social Psychological Issues in Organ Transplantation

Ethical, cultural, and psychological issues associated with organ transplantation touch on issues of sacrality and human mortality. The use of the bodies of the dead for transplantation purposes stirs fears of contamination and violates some sociocultural taboos. Also the use of brain-dead donors alters cultural representation of death and dying. Thus, although organ donation is defined as an altruistic and meaningful act, it has been associated with some recipient anxieties, such as the fear that some psychological qualities of the donor may be transferred along with the organ. Similarly, patients receiving organs or the family of the donor may believe that organ transplantation entails more than the transfer of an impersonal organ, but also entails part of the soul of the deceased and implies reciprocal social and emotional obligations.

A serious ethical concern related to chronic scarcity of organs is the documented existence of a widespread illegal organ trafficking (mainly of kidneys), organized by international crime organizations that profit on poor and underprivileged "organ sellers" and buyers from richer countries in need of a transplant. China, which has advanced organ transplantation programs, has been subject to international criticism for its use of the organs of executed prisoners in replacing organs in cadres and "medical tourists." Kidney transplantations, for instance, sell for $70,000 to $80,000. More than 90% of all organs in China are obtained in this way, with the executions scheduled to fit the arrival times of recipients.

The Future of Organ Transplants

Important obstacles for further developments in organ transplantations are endemic organ scarcity and problems of immunosuppression, or organ rejection. One alternative solution, still under experimentation, is xenotransplantation, transplantation with graft organs from *transgenic pigs* (pigs carrying human genes that make the organs more compatible to human recipients). However, xenotransplants imply the transgression of yet another taboo in crossing the barrier between species by merging recipient and "donor" into a chimera, a mythological being part human and part animal.

Nora Machado

See also Brain Death; Death, Clinical Perspectives; Defining and Conceptualizing Death; Life Support Systems and Life-Extending Technologies

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Orphans

Orphans are defined as children (age 0–17) who have lost their parents through death or abandonment. Children who have lost one parent are described as single orphans, while those who have lost both parents are known as double orphans. Those who have lost their mothers are known as maternal orphans, and those who have lost fathers as paternal orphans. The reasons children become orphans are varied. Parents may die due to physical or mental illness, accidents, natural or man-made disasters, crime, violence, war, drug use, suicide, murder, HIV/AIDS, and endemic or epidemic plagues. The death rates of young adults in countries with poor health care support and poor occupational safety are higher than in more developed

societies with effective health and welfare provision. Deaths of young adults are more likely to leave young children orphaned.

Children are abandoned by their parents for a number of reasons. Causes of abandonment may be due to political instability, asylum seeking, unwanted pregnancies, poverty, rape, gender selection (prefer boys, kill or throw away girls), government policies (for instance, one child per couple policy and no support for children of migrant workers in China), unwillingness to keep sick children (medical costs are unaffordable) or disabled children (infants with observable disabilities or deformities), imprisonment of parents, and political persecution.

Numbers of Orphans

There is no reliable worldwide estimate of orphans, although a number of international organizations have attempted to give an idea of the extent of the problem, including UNICEF, UNAIDS, and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). According to their figures in 2006, there are more than 132 million orphans (including those who have lost one or both parents) in the 5 most affected regions of the world (sub-Saharan Africa, Asia, Latin America, and the Caribbean). They estimate that over 10% of all orphans in these regions have lost both parents. The percentage of double orphans out of the total population of children in sub-Saharan Africa is 2.4%, and in Latin America and the Caribbean it is 2.6%, which is 3 times greater than their worldwide estimate of the percentage of all children who are double orphans (0.8%).

If single orphans are included in the analysis, the percentage is even more alarming. Compared to Asia, Latin America, and the Caribbean, where 6% of all children are orphans, 12% of all children in sub-Saharan Africa are orphans. The large numbers of adult deaths in poverty-stricken areas is also due to a lack of safe drinking water, poor nutrition and hygiene, lack of affordable and accessible health care, infectious diseases, drug abuse, HIV/AIDS, war, racial conflict, and violence. Poor maternity care often results in high rates of maternal mortality, especially in South Asia and sub-Saharan Africa. With economic growth and vigorous attempts to eradicate poverty, the number of orphans in Asia, Latin America, and Caribbean is expected to drop. Unfortunately, the number of orphans in sub-Saharan Africa is still expected to rise due to uncontrolled and untreated HIV/AIDS.

AIDS Orphans

The numbers of orphans are extremely high in some regions of sub-Saharan Africa. Nigeria alone has an estimated 930,000 AIDS orphans. The role of AIDS in creating orphans in Uganda, Nigeria, Tanzania, Rwanda, Zimbabwe, and Botswana has been widely reported. In a study of a rural community in western Kenya, 1 out of 3 children below 18 years of age had lost at least 1 biological parent, and 1 out of 9 had lost both. Another study of AIDS orphans in Kenya found that more than 12% of orphaned children wished that they were dead, compared to less than 3% of nonorphaned children. Many of the orphaned children suffered from poor sleep, stomach problems, and had little hope for their future.

AIDS orphans were also found to have higher levels of negative mood and pessimism compared to nonorphans because of the strong social stigma and material and emotional deprivations that they experienced. They have been traumatized by watching their parents slowly die. Their bereavement is complicated by worries about their own health, as well as being seen as unclean and contagious by others.

Sudden Traumatic Deaths of Parents

Parents' death due to illness may often provide children with time to prepare socially and psychologically for the loss. In situations of violence, suicide, and trauma, the death of parents is sudden and unexpected. Additional stigma is attached to suicide because of the association with mental illness, religious prohibitions and punishments, and cultural beliefs about evil spirits. Many orphans suffer from post-traumatic stress disorder especially when they witness their parents' traumatic deaths.

Care for Orphans

Paternal orphans are often taken care of by their mothers as a single parent, which means that despite their loss, children can still grow in a supportive environment with love and care. The

situation of maternal orphans is often more difficult. Widowers tend to remarry quickly so that children of the first wife are raised by a stepmother. There are many cultures where it is harder for widows to remarry. The situation for widows in less developed regions is often harsh, as financial strain may be coupled with cultural oppression and discrimination. Widows may not be able to inherit their deceased husband's land or estate. Besides loss of income, female-headed households are vulnerable to sexual harassment and robbery.

Children who have lost both parents are often looked after by grandparents, or older siblings will take charge of managing the home. Such households are clearly vulnerable. Many orphaned children in poor countries will have to toil as child labor in order to feed themselves and are deprived of schooling. Brothers and sisters who have lost both parents may find themselves separated and raised in different institutions or by different foster or adoptive parents. These orphans will experience multiple losses, a total uprooting from all familiar social networks and affectionate relationships as well as kinship and community support systems. Generally, children thrive when they have opportunities for education, social and emotional support, vocational training, moral education and care, and where these resources are linked to intimacy between caregiver and children. This is why substitute homes with foster or adoptive parents are increasingly preferred for orphans.

Depictions of Orphans in Print and Film

In Western fairy stories, movies, and novels, there is a strong theme that originated centuries ago about the poverty and mistreatment of orphans from Cinderella and Snow White, through Jane Eyre and Oliver Twist, to Harry Potter and Lemony Snicket. One recent study of children's literature found that out of 56 orphaned children who appeared in folktales, 30 were portrayed as maltreated.

These stories serve at least three purposes. The first is to remind children how lucky they are and that they should be compliant and obedient to their parents, study hard, and appreciate what they have. The second is to suggest that deprivation and hardship are good training for resilience. Hostile environments can incubate noble characters. The third is to cultivate a sense of compassion for underprivileged people by addressing the pain and hurt of the wounded child.

Resilience and Orphans

There are real stories of distinguished people who survived being orphaned as children and who have become inspirational role models, outstanding professionals, and leaders in history. They include Nelson Mandela, Mother Theresa, and Chiang Kai-shek, all of whom had lost their fathers by the age of 9, and Queen Elizabeth I of England whose father, King Henry VIII, famously beheaded her mother when Elizabeth was 3 years old. With the experience of abandonment, fear, insecurity, and uncertainty, orphans often develop a sense of compassion for other underprivileged populations. They may have a stronger drive to serve and fight for the livelihood of deprived individuals and groups.

Orphanages and Child Welfare

With disintegration of extended family systems and neighborhood mutual help, government and nongovernmental organizations need to intervene to provide care and support for orphans and children in need. This can take different forms: institutional care, small group homes, foster care, community support, and adoption. Institutional care (i.e., orphanages) can often attract resources and funds because of its economies of scale, better promotion, and fund raising, although they are not necessarily the best solution for children. Large-scale nongovernmental organizations (NGOs), such as SOS Children's Villages, World Vision, UNICEF, Serving Our World, Half the Sky Foundation (serving orphans in China), Gaurav Youth Unity Society (serving orphans in Nepal), and so forth are promoting different forms of service structures to provide orphans with effective care. Governments often facilitate institutional care because obvious gross child neglect creates bad publicity and invites criticism of competence in public governance.

Developmental Problems of Orphans Raised in Institutions

In the late 1930s, psychologists began investigating the development of children who were brought

up en masse in institutions. Commonly cited problems include delays in emotional, motor, social, speech, and physical development; severe behavior and emotional difficulties, such as aggressive or antisocial behavior; as well as underperforming intellectually. John Bowlby subsequently developed his highly influential attachment theory. This identified the importance of the development of a secure and continuing attachment to a stable caregiver during infancy for the development of a mature and secure adult personality.

Recently, research by UNICEF has found that orphans are more deprived of education, socialization, and nutrition than their national peers. Thus, without protection of family or state, orphans are likely to face isolation, prejudice, crime, abuse, neglect, child labor, prostitution, exploitation, and HIV infection. Problems in orphanages may be caused by the lack of labor, training, and resources to provide the necessary human understanding for infants and children. Rapid staff turnover, staff burnout, and tight budgets are common problems. Large-scale orphanages in Russia, Romania, North Korea, and China have all been extensively criticized for gross child abuse and neglect in the last decade.

Adoption

Orphans can be given a new home through adoption. Formal adoptions are often managed by statutory organizations that involve the judicial system, although some countries still permit informal adoptions. However, the number of infants available for adoption in major cities in affluent societies is declining because of the widespread availability and use of contraception and, in some circumstances, termination of pregnancies. Many couples have to resort to developing countries to look for babies to adopt. Africa, China, Eastern Europe, and Asia are suppliers of children for international adoption, which has become controversial.

There were about 127,000 children adopted annually in the United States in 2000–2001, a number that has remained relatively constant since 1987. Adoptions are no longer dominated by kinship adoptions and private agency adoptions; public agency and intercountry adoptions now account for more than half of all adoptions in the United States. Adoptions through publicly funded child welfare agencies accounted for 40% of all adoptions (up from 18% in 1992). Intercountry adoptions accounted for more than 15% of all adoptions (increased from 5% in 1992). As well as a lack of adoptable American children, there are also concerns about the uncertainties inherent in domestic adoption, such as birth parents failing to give up their rights or reclaiming a child already placed in an adoptive home. According to the U.S. Department of State, more than 22,000 children were adopted from outside the United States, particularly from Mainland China (6,493), Guatemala (4,135), Russia (3,706), South Korea (1,376), and Ethiopia (732). Critics have described international adoption in the United States as modern-day slavery, child trafficking, and cultural and racial hegemony.

Finally, children are the future. Prevention of adult death through hygiene and occupational and environmental safety is crucial. Empowerment of women, education on gender equality, sanctions for discrimination against women and girls, improvements in public safety, and services for children with illness or disabilities can help reduce the abandonment of children.

Cecilia Lai Wan Chan

See also Causes of Death, Contemporary; Causes of Death, Historical Perspectives; Childhood, Children, and Death; Depictions of Death in Television and the Movies; Epidemics and Plagues; HIV/AIDS

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Palliative Care

Palliative care is comprehensive, holistic care that concentrates on improving quality of life rather than on curing disease. The term *palliative* is derived from the Latin *palliare*, meaning to cloak. It encompasses hospice end-of-life care but is not limited to it. Palliative care is used along with treatment of disease in some situations.

In the broadest sense palliation applies to any situation when the treatment of symptoms is the focus. For instance, there is no cure for the common cold, and treatment is for relief of symptoms. Similarly, physical therapy, applications of heat and cold, and pain medications are palliative for back pain but not curative. In practice, however, the term *palliative care* refers to relieving suffering and improving the quality of life of patients experiencing life-threatening or life-limiting complex, serious illness. Palliative care is appropriate for patients at any stage of illness.

History

Palliative care has been part of health care for centuries. In the 4th century C.E., early Christians were known for providing hospice care to injured travelers and the seriously ill and dying. Fabiola, a Roman noblewoman, provided financial support and served as a nurse in hospice care and gave impetus to the movement.

The modern palliative care movement began in the mid-1960s. Dame Cicely Saunders established St. Christopher's Hospice for the care of the terminally ill in England in 1967. Her focus was relief of suffering and compassionate support for patients at the end of life. The hospice movement began in the United States in 1974 through the community-based home care program in New Haven, Connecticut. The first hospital palliative care program was also established in 1974, at St. Luke's Hospital in New York City. The hospice and palliative care programs focused on relief of pain and other symptoms as well as the emotional and spiritual concerns of dying patients and their families. More hospital-based palliative care programs began in the 1980s. Since then, the number has increased to more than 1,200. Over half of U.S. hospitals with 100 beds or more have a palliative care program.

The American Academy of Hospice and Palliative Care Medicine was established in 1988 to provide certification and continuing education for physicians who are in palliative care. The academy's focus is the "science of comfort and the art of caring" in life-limiting or chronic illness. In the early days, physicians in the palliative care movement often felt as if they were second-class citizens among their medical colleagues. Hospice and palliative care medicine is now an established subspecialty in medicine.

Care Recipients

Palliative care may be delivered in the hospital, nursing home, in-patient hospice, or at home. The patient and family are the recipients of care and are at the center of the health care delivery model.

Programs are available for patients of all ages, including children, and at any stage of illness. The care providers work together as a team to help relieve suffering and improve quality of life.

Patients with complex, life-threatening, or life-limiting illnesses are the recipients of care. Some of the medical diagnoses are cancer, cardiovascular disease, respiratory disease, kidney failure, Parkinson's disease, Alzheimer's disease, AIDS, amyotrophic lateral sclerosis, and multiple sclerosis. When patients are referred for hospice palliative care, they have approximately 6 months or less to live; the most common diagnosis among these patients is cancer. Other patients receiving palliative care may be receiving therapies for the underlying diagnosis simultaneously. The common factor with hospice and nonhospice palliative care patients is that they have complex health problems and can benefit from holistic, compassionate relief of physical, psychosocial, and spiritual suffering.

Funding for Care

Most insurance plans cover all or part of palliative care services in hospitals. Terminally ill patients may have coverage through their private insurer. Those who are age 65 or over and on Medicare are eligible for the Hospice Medicare Benefit. The patients and families must commit to accept the benefit with plans not to seek further curative therapies. A set daily fee is given to the approved hospice program to provide terminal illness care. If the patient improves, the benefit may be suspended and the patient will return to regular coverage. Those without insurance are served through Medicaid (the state and federal program for the indigent) or through charity services of the hospital or hospice program.

Interdisciplinary Team

Palliative care providers include professionals and volunteers. All have special education and training in palliative care. A physician, usually an internist or family practitioner, leads the team and writes the orders for therapies to be used. A psychiatrist (also an M.D.) may participate to determine psychological needs and medications that may be helpful. One or more nurses help to develop the plan of care and direct care to patients and their families. A clinical psychologist or social worker may serve in a counseling capacity. Social workers also help to resolve financial issues. Pharmacists provide consultation about appropriate medications, especially those for pain control. A chaplain is available to assist with spiritual aspects of care for the patient, the family, and the staff as well. If the patient has a spiritual advisor, the chaplain may serve to encourage and facilitate that relationship. Other professional team members may be a physical therapist, a music therapist, a specialist in therapeutic touch or massage, or an acupuncturist.

Volunteers serve an important role in the care of hospice patients. They may be assigned to a family in home care and provide companionship, assist with errands, bring meals, or do whatever will be helpful to the family and the patient. They are required to participate in a volunteer training class prior to making the visits. The volunteers do not perform direct patient care but provide support in a variety of ways.

Palliative Care Practices

Dame Cicely Saunders described the physical and psychological distress of seriously ill patients as total suffering. The goal of palliative care is to help the patient find comfort and relief from the suffering and to enhance quality of life as long as the patient lives. That may include helping them prepare for approaching death. The implementation of palliative care does not preclude the continuing use of more active therapies by the primary physician or oncologist. Even with hospice patients, radiation and chemotherapy may be continued for pain control and symptom relief. The palliative care team works closely with the primary physician to assure that palliative practices complement the ongoing active therapies.

The palliative care team members do an initial assessment of the physical, psychosocial, and spiritual needs of the patient and the family. This is an essential first step in determining the priorities of care.

Pain is often the physical symptom that is creating the greatest stress. When the patient is comfortable, other issues are much easier to address. Ideally, the physician, the patient, the family, the nurse, and other providers confer to determine the medications and their administration to provide the most comfort without unpleasant side effects,

such as somnolence or confusion. Other complementary modalities may be gentle massage, acupuncture, or guided imagery to help in pain relief.

Nausea may accompany chemotherapy or radiation treatments or be a result of the underlying disease process. The palliative care team uses appropriate interventions to help reduce this annoying symptom.

Loss of function symptoms, such as urinary continence or mobility, also creates distress and may affect the patient's coping ability and relationships with family. If the patient is at home, the family caregiver may have difficulty knowing how to assist the patient as function changes. The team members may suggest a urinary catheter to assist the patient, keep the skin dry, and make care easier for the family member. Additionally, the team physical therapist is available to help the patient increase mobility as much as possible. The patient can have benefit not only by being able to be more independent but also by the sense of accomplishment and relief that care is easier for the family member.

Other physical symptoms may be swelling that is creating pain, inability to talk following a stroke or surgery for a brain tumor, changes in vision or hearing, or amputation. The palliative care team can help the patient get needed help with these and other physical problems that are creating distress.

The team is very concerned with the psychological stress of the patient and the family member. Active listening is a skill that is crucial to all the team members. The patient may express signs of depression, suicidal tendencies, relationship problems with family members, and other emotional problems. The good listener who spends time with the patient can identify the major concerns. Often the patient will share thoughts and concerns with the care team member that he or she cannot easily talk about with a family member. Additionally, treatment with a mild antidepressant may reduce a patient's distress and improve coping skills.

Spiritual support is appropriate for all patients and families, whether or not they have a religious preference. The chaplain or another team member may do a spiritual needs assessment to determine how the team might be of support, particularly with the stress of a life-threatening diagnosis or approaching death. Listening to the patient's concerns and questions about why things are happening, where God is, and what the patient's relationship to God consists of is often very helpful so that the patient may move toward personal answers or simply feel free to raise questions out loud. Some patients find that doing a life review, either orally or in writing, helps them to identify positive accomplishments and values to pass on before they depart. Writing or other creative efforts may be helpful to both patients and family members as they cope with the situation.

Family members are included in palliative care. They participate in planning the care for the patient, and they are given emotional and spiritual support as needed. The primary caregiver in a home situation is offered respite care to take a break and get rest and emotional refreshment.

Palliative care is comprehensive and is individualized for each patient and family. All involved mutually agree upon the assistance that the team gives. The patient and family choose whether to participate in a formal palliative or hospice program and may discontinue services at any time.

Education for Palliative Care

In the past, medical and nursing education programs had little content on end-of-life care. A 2007 study reports on a survey of 122 medical schools and 580 baccalaureate nursing programs to determine the curriculum content related to death education. All of the medical schools and 99% of the nursing programs surveyed had some content, but the average number of hours was less than 15.

There are a number of medical schools, however, that have been proactive in developing palliative care centers and educational programs. The Center for Palliative Care of Harvard Medical School in Boston began in 1996 under the leadership of Loring Conat, M.D. It is a collaborative program with Massachusetts General Hospital, the Dana Farber Cancer Institute, Brigham and Women's Hospital, and the Children's Hospital of Boston. Medical students take palliative care courses in their first and second years of study and work directly with dying patients and their families. Internists or family practice physicians are eligible to apply for a 1-year fellowship program in palliative care. Continuing education programs for physicians, nurses, and other professionals are offered throughout the year. The center has publications on various topics related to palliative and end-of-life care.

From 1996 to 2006 the American Academy of Hospice and Palliative Care Medicine awarded subspecialty certificates in hospice and palliative care to 2,883 physicians in the United States. In September 2006 the National Board of Medical Specialties approved hospice and palliative care as a subspecialty in medicine. The National Board of Certification of Hospice and Palliative Care Nursing certifies advanced practice nurses, basic registered nurses, licensed practical nurses, and nursing assistants in various aspects of hospice and palliative care as well.

Linda Olivet

See also Caregiving; Hospice, History of; Pediatric Palliative Care; Quality of Life; Terminal Care

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Pediatric Palliative Care

Pediatric palliative care is both a philosophy of care and an organized program for delivering care to children with life-threatening conditions and those children's families. The recognition that the child and the family are the unit of care is the foundation upon which palliative care is based. Palliative care promotes clear and culturally sensitive communication among the child, family, and their primary caregivers that assists the family to understand the diagnosis, prognosis, and benefits and burdens of treatment options. It is an integrated approach in which medical science and humanism are merged with the goal of addressing physical, psychosocial, and spiritual needs of these children and their families. It is achieved through an interdisciplinary approach that uses a combination of active and compassionate therapies designed to enhance quality of life for the child and family, thereby minimizing suffering, optimizing function, and providing opportunities for personal growth. Pediatric palliative care is not simply providing care at the end of a child's life; the pediatric palliative care philosophy should be implemented at the time of diagnosis and continue through the child's death, attending to families' needs during bereavement. Palliative care is appropriate over the continuum of a progressive, life-threatening condition and may be initiated in conjunction with curative treatment.

History of Pediatric Palliative Care

The hospice movement that began in the 1960s with the establishment of St. Christopher's Hospice by Dame Cecily Saunders in London, England, laid the foundation for providing care for individuals with life-limiting illnesses and their families in specialized locations. In the United States, the hospice movement grew from a grassroots beginning with most programs designed as home care support. The hospice concept was adapted to hospital settings of caring for the dying with the establishment of the first hospital-based palliative care unit in Montreal, Canada, established by Dr. Balfour Mount, who coined the term *palliative care* in 1972.

The development of palliative care for children followed the early footsteps of adult models of care and thus has a more recent history. Loci of care available for palliation in children can be loosely categorized into inpatient, primarily tertiary care children's hospitals, or domiciliary facilities and outpatient or home-based programs. In some places, home care programs are coordinated through inpatient facilities. In addition to the standard

hospital, there are freestanding palliative facilities, commonly referred to as hospices. The first of these, Helen House, established in England in 1982, led the way for the establishment of nearly 40 similar facilities throughout the United Kingdom and for the first freestanding children's hospices in North America (Canuck Place in Vancouver, Canada, in 1995), in Australia (Bear Cottage in Sydney in 2000), and in the United States (George Mark Children's House near San Francisco in 2004). In Canada, the hospice concept was applied to children's hospital settings in the mid-1980s with pediatric palliative care programs in both Toronto and Montreal Children's Hospitals. In the United States, the early pediatric palliative care movement was primarily directed toward supporting the dying child and family in their home environment, beginning with Dr. Ida Martinson's pioneering the first home care program for dying children in Minnesota in 1972. The first U.S. hospital-based pediatric palliative care program started in 2001. In hospitals, the pressure for delineated areas for children receiving palliation came originally from those services carrying significant numbers of children with chronic illness in their terminal phase, such as oncology and cystic fibrosis services. In the past decade, many children's hospitals have instituted palliative care programs to provide support and follow-up to children with these and other life-limiting conditions.

As the field developed, professional and national organizations became involved in pediatric palliative care. The Association for the Care of Children with Life-Threatening Illness, based in the United Kingdom, and Children's Hospice International, based in the United States, were among the first. In the United States, the Institute of Medicine report on the status of end-of-life care for children served as an impetus for attention to pediatric palliative care. National groups such as the National Hospice and Palliative Care Organization in the United States, the Canadian Hospice and Palliative Care Association, and the European Association of Palliative Care actively support pediatric palliative care endeavors; standards of practice have been developed. Various medical and nursing professional organizations have published position papers pertaining to pediatric palliative care. The number of research reports and textbooks has increased since 1993, when the first publication pertaining to pediatric palliative care appeared in the first edition of *The Oxford Textbook of Palliative Care*. Finally, joint projects have contributed to improvement of pediatric palliative care within host countries and, more recently, across the world.

Differences Between Pediatric and Adult Palliative Care

Compared to palliative care for adults, certain concerns are unique to or particularly evident in children. Foremost, the death of a child is never viewed as normal or natural and always as tragic, unlike our customary expectations of death as a natural phenomenon in an older adult.

Smaller numbers of children die, compared with adults, and from heterogeneity of illnesses, some of which are familial in nature; thus, more than one family member may have the same condition. Many pediatric illnesses are rare and follow irregular disease trajectories, making diagnosis, prognosis, and medical management even more difficult and uncertain than it is for seriously ill adults. Advances in technology and pharmacology have produced benefits, enabling the survival of many children who might otherwise have died from life-threatening conditions, such as extremely premature newborns or children with congenital cardiac abnormalities. In all such cases, the ethics of care forces the question of whether aggressive care is always justifiable. Ongoing discussion considers this question, along with questions pertaining to uncertainty, quality of life, and assent and consent. Even when death is imminent, the need exists for blending of curative and palliative care models; optimally, initiating palliative care principles should occur at diagnosis even though complex ethical, legal, and health policy issues affecting children further complicate the timely provision of pediatric palliative care.

Children are not small adults. Obvious physiological and pharmacokinetic differences between children and adults influence management. Developmental differences must be considered when dealing with pediatric patients who range from neonates to adolescents and young adults, and managing their care must adapt over time as they change developmentally (i.e., cognitively, emotionally, physically). Furthermore, focusing on the well-being and suffering of the family takes on greater emphasis in pediatrics. Parents are integral to the

care team, as they are direct caregivers, legal guardians, and decision makers for their child. Siblings and peers are greatly impacted by the illness and death of the ill child; grandparents too have unique needs. Language and cultural variances, cognitive development, and family dynamics must all be considered. As a result, the care team often comprises a wide variety of professionals, including child life therapists or school teachers. Most children with serious illnesses are treated in tertiary care centers, often far from their home communities. When children leave the hospital, an adult palliative care service or community hospice may be the only available source of hands-on pediatric care. Thus, despite the salient differences between the adult and pediatric realms, adult-focused practitioners may also be members of the pediatric palliative care team.

Population Served

As expertise in pediatric palliative care expanded, the importance of developing services for children with conditions other than cancer was acknowledged. Four patterns of disease progression describe children and adolescents requiring palliative care:

1. Conditions for which potentially curative treatment has failed (e.g., malignancy)
2. Conditions for which intensive treatment may prolong and enhance life, but premature death still occurs (e.g., cystic fibrosis)
3. Progressive conditions for which treatment is almost exclusively palliative but which may extend over many years (e.g., neurodegenerative conditions)
4. Nonprogressive neurological conditions that result in an increased susceptibility to complication and premature death (e.g., severe cerebral palsy)

Palliative care services for children continue to be underutilized. In the United States, it is estimated that more than 50,000 infants, children, adolescents, and young adults (up to age 24) die annually from the complication of a complex chronic condition. On any given day, it is estimated that 5,000 of these patients are within the last 6 months of their lives. Most children's deaths in the Western world occur in hospitals, and most of these, in neonatal or pediatric intensive care. Children with a complex chronic condition who die in hospitals are likely to experience periods of mechanical ventilation and hospitalization before death. In addition, accidental deaths remain the leading cause of deaths in children and adolescents; many of these deaths occur in emergency departments or pediatric intensive care units. Even if the time in hospital is brief due to traumatic injury and subsequent death, all salient principles of palliative care are fully applicable.

Barriers to Optimal Pediatric Palliative Care

Several barriers to providing optimal pediatric palliative care have been identified: fear and denial of the child's prognosis, silence about the topic of death among practitioners and families, uncertainty of outcomes, and delayed identification of the need for palliative care; limited financial resources for specialized pediatric care, fragmented follow-up care after discharge from hospital to the community, and limited access to specialty care in rural areas; inadequate assessment and management of symptoms, communication problems, and inattention to psychosocial and spiritual issues; false hope for cure, inappropriate continuation of advanced life-saving technology, and ethical and legal issues; lack of research on pediatric palliative care; and lack of training and expertise among health care providers.

Ongoing development of pediatric palliative care must address these barriers. Several barriers are associated with the clinical context in which palliative care is provided. Specialized time, expertise, and resource requirements are essential for providing care to children with life-threatening conditions. It is recognized that limitations in funding and staffing are paramount concerns and can restrict providers' capacity for providing the specialized palliative care needs of critically ill children, as well as restrict capacity to create environments that foster communication and attention to psychosocial concerns of children, families, and health care professionals. The inadequacies of professional education and training in end-of-life issues have prompted leaders in the health care community to target these issues for intensive reparative efforts. Enhancing the interdisciplinary

collaborative nature of practice and fostering instructional mentoring relationships to improve palliative care for children and their families are increasingly being implemented. Because working with terminally ill children is intense and sometimes overwhelming, attention is being directed to the needs of health care providers.

Other barriers pertain to the underlying situation of uncertainty in confirming a diagnosis, predicting prognosis and disease trajectory, or predicting treatment response. Moreover, uncertainty motivates families and providers alike to continue curative treatments that may delay or limit the discussion of the possibility of death until late in the disease course. Historically, palliative services were initiated when curative therapy was no longer appropriate and the child was "dying." However, all children in the categories of life-threatening illnesses are at risk for premature death. Therefore, the initiation of palliative services is based more on the underlying disabilities (physical, emotional, and spiritual) that the illness brings to the child and family as well as their underlying needs for support. Discussions must occur between and among providers, patients, and families about their goals, be they to eradiate disease, extend life, enhance comfort, and promote quality of life and support of the family during life and after death.

Future Directions

Provision of palliative care for seriously ill children began to garner much support during the late 20th century. Impressive improvements have resulted through addressing known shortcomings and progress continues in developing the field. Future avenues will continue to investigate ways of optimizing care of children who will likely die before adulthood and focus greater attention to the palliative care of diverse children and families within the Western world as well as in developing countries where life-limiting conditions among infants, children, and adolescents present unique challenges.

Betty Davies

See also Adolescence and Death; Caregiving; Childhood, Children, and Death; Hospice, History of; Neonatal Deaths; Palliative Care

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Persistent Vegetative State

Persistent vegetative state is a medical syndrome produced by brain damage. In persistent vegetative state, the patient is awake but does not demonstrate cognitive ability and shows unawareness of the self and the environment for at least 1 month. The person demonstrates no purposeful, sustained, or voluntary behavioral responses to visual, auditory, tactile, or noxious stimuli, and there is no language comprehension or expression. There is bladder and bowel incontinence and preserved cranial nerve and spinal reflex function; sleep–wake cycles may be normal. The state often occurs following coma and is caused by traumatic brain injury or oxygen deprivation. The term *persistent vegetative state* may be somewhat misleading

in some cases. In the United Kingdom, the Royal College of Physicians recommends using the terms *vegetative state, continuing vegetative state,* and *permanent vegetative state* to distinguish between early and late stages of the syndrome, and because the patient may, indeed, recover, at least partially.

Clinical Features

The brain represents only 2% of body weight but accounts for 20% of oxygen utilization. Lack of oxygenation (anoxia) for more than 2 to 4 minutes leads to rapid destruction of brain cells; the extent of injury increases with the duration of oxygen deprivation. Extensive brain damage results in brain death, and somatic death follows rapidly. The development of cardiopulmonary resuscitation (CPR), artificial respiration, and other technologies has made it possible to keep people alive after motor accidents, drowning, and cardiac arrest. Because CPR can keep the person alive for long periods of time, different levels of brain damage and consciousness can occur, depending on the duration of anoxia during the resuscitative process. If the person survives, extensive brain damage sometimes leads to a partially conscious state without purposeful behavior inconsistent with a sapient existence. This particular condition was first named *persistent vegetative state* (PVS) in 1972 by Jennett and Plum. It is different from brain death where there is no consciousness, motor function, or electroencephalographic activity.

There are several states of altered consciousness that may be confused with PVS. *Coma* is a state of unconsciousness that may or may not be reversible and can occur with or without brain damage. *Minimally conscious state* (MCS) is a condition distinct from coma and PVS with inconsistent and erratic responsiveness that may last for years. Generally, MCS has a better prognosis than does PVS. It is also different from *locked-in syndrome*, in which the patients are aware of the self and the environment but have lost motor function and speech.

Brain Death and the Definition of Death

Brain death is a state of irreversible destruction of the brain. Criteria for diagnosis include deep coma and absence of any brain-stem functions (e.g., spontaneous respiration, pupillary reactions, gag and cough reflexes). Hypothermia, drug overdose, and poisoning should be excluded. Electroencephalography is useful, but not essential, in determining brain death.

For centuries, the diagnosis of death was based on permanent cessation of breathing and the heart beat. Because of technological advances and ethical and legal implications, a restatement for the traditional definition of death was needed. A presidential commission was formed, and in 1981 it issued a report on the definition of death in the United States. Because of ongoing changes in technology, increasing sophistication in medical knowledge, and refinement of techniques, the definition of death was based on clinical physiological standards rather than solely on medical criteria and tests. This statutory definition was to be kept separate and distinct from provisions governing criteria for organ donation and termination of life support. The report does not deal with the medical, legal, and ethical issues in brain-damaged or dying patients.

Causes and Clinical Diagnosis

The most frequent causes of PVS are direct head trauma, anoxic brain damage from cardiac arrest and near-drowning, or prolonged periods of severe metabolic disruption. Other causes include hemorrhagic stroke, sepsis and serious infections, and prolonged increased intracranial pressure from tumors or abscesses.

Accuracy of diagnosis in PVS is often difficult because objective assessment of residual cognitive function is a problem since motor responses to verbal commands during neurological examination are inconsistent, variable, and may seem purposeful at times. Tests such as magnetic resonance imaging (MRI) and computed tomography (CT) scans show the extent of brain damage, but these tests cannot demonstrate functional capacity. Moreover, it is difficult to determine if and when recovery will occur. Unlike brain death, there are no agreed-upon criteria or tests that will confirm the diagnosis of PVS. However, it is more or less agreed by many experts that a diagnosis of PVS on neurological examination should have the following components: (a) wakefulness without detectable awareness, (b) lack of purposeful motor activity, and (c) lack of cognitive function. Postmortem, the brains of patients with PVS are

heavily damaged with loss of matter, reduced weight, and enlarged ventricles. The most consistent finding is diffuse axonal injury and widespread degeneration of subcortical white matter; often there is damage to the thalamus.

Prognosis

In PVS, the patient will either eventually recover, though not necessarily fully due to residual brain damage, or remain in PVS until death. Infection is the leading cause of death in patients who do not recover. In some cases, patients spend decades in PVS until death occurs. In general, prolonged survival is rare. The older the patient is, or the longer he or she has been in PVS, the less likely it is that the patient will recover.

Because of a lack of uniformly standardized medical criteria and diagnostic tests for PVS, there have been several controversial legal cases related to the diagnosis and prognosis for recovery and serious disagreement about withdrawal and termination of care in PVS. Notable controversial cases have included those of Terri Schiavo in 2005, Nancy Cruzan in 1990, and Karen Ann Quinlan in 1975. Although these cases have been extensively adjudicated in court, there is still no uniform agreement on how best to determine if life support should be continued or terminated.

Ethical and Legal Considerations

The moral, ethical, and legal difficulties with discontinuation of life support and the withdrawal of medical care are the key issues in both brain death and PVS. In the Western world, the legal definition for brain death is better established than that for PVS. With brain death, guidelines are well established for discontinuation of mechanically assisted respiration, tube feeding, and ongoing medical care in order to allow somatic death to occur. Additionally, there are guidelines for organ harvesting for transplantation in brain-dead patients. However, despite the establishment of such guidelines, ethical debates on all of the previously mentioned types of care continue. These debates about brain death are based on ethical and personal values, emotional considerations, and moral and religious views.

With PVS the situation is even more complicated because the person is not actually brain dead and demonstrates movement and partial consciousness to caregivers and relatives, in part because the diagnosis and prognosis of PVS are often unclear, and the difficulty loved ones may experience in accepting PVS as being potentially irreversible. The lack of clinical certainty in diagnosis and prognosis provides an opportunity for differences in medical opinions and for the appropriate course of action to be taken in an individual case. Inevitably, such situations lead to an appeal for legal relief to define the limits of medical care. The cases of Quinlan, Cruzan, and Schiavo were helpful in establishing the legal parameters for the withdrawal of care. Such case law has allowed physicians and families of a PVS patient to make decisions jointly in order to avoid legal proceedings.

In cases where there is conflict between doctors and patients' families, or among family members, the principle of *substituted judgment* may be applied. In substituted judgment, the law recognizes that recommendations for withdrawal of care may be based on testimony from a responsible person (e.g., a spouse, a relative, a partner, or a close friend), who states that the patient had expressed a prior wish that he or she would not desire to be kept alive on life support and would not want to have extraordinary means taken to revive him or her, should a medical catastrophe occur.

The "Do Not Resuscitate" Order (DNR)

A separate but related issue is the "do not resuscitate" (DNR) recommendation. Many physicians would also make a DNR recommendation to relatives of a patient in PVS should a cardiac or respiratory arrest occur. Before a DNR order is issued, a full neurological examination is done to establish extensive brain destruction, exclusion of the dulling effects of sedatives, toxicity from drugs and chemicals, and agreement among the treating physicians that a persistent state of severe brain damage is present. All medical consultants should agree that the prognosis is irreversible. A clinically catastrophic event should be viewed as "a natural ending of life" rather than as an abandonment of medical care by medical staff. It should also be stated explicitly to the family that the reason for recommending a DNR order and/or for discontinuing artificial life support is not based on cost consideration; clearly,

this would be unethical. Additionally, a clear distinction should be made between the DNR order and withdrawal of care on the one hand, and euthanasia and assisted suicide on the other—distinctions not always understood by the lay community.

In the United States in both PVS and brain death cases, issuing a DNR order or the withdrawal of care does not ordinarily require consent from the courts. Admittedly, the situation in PVS is a much more difficult one, and the risk of a malpractice lawsuit may prevent physicians from making a recommendation to withdraw medical care to allow death to occur. Therefore, it is essential for medical staff to document in the medical record the medical evaluation procedures, discussions with relatives or responsible caregivers, and the outcomes of such meetings. There should be complete concurrence among all interested parties (or with the person having power-of-attorney) that both withdrawal of care and the DNR order are unanimously agreed upon in order to minimize the risk of lawsuits for negligence. There remains the difficult problem of cases in which the family refuses to allow the withdrawal of care to a family member in PVS after many years of care, during which time the cost of such care is borne by the institution. In these cases, litigation may be forced by the hospital, as there may be genuine conflict between the institution and the patient's family.

Because of the possibility of irreversible brain injury in the future, some healthy individuals now make decisions ahead of time when they are still mentally competent, so that in the event of serious illness, they can advise caregivers and relatives what may be done to limit care. It is customary now in the United States to have a discussion before a major medical or surgical procedure to document the patient's wishes in the event of a catastrophe rendering them mentally incompetent. Families also often have such discussions ahead of time to document their wishes in a "living will." Many people appoint a proxy or grant a durable power-of-attorney to a responsible person to allow decisions to be made should they become mentally incompetent. Although such steps are extremely valuable in clarifying the wishes of a patient should they be rendered mentally incompetent, they do not alter or remove the ethical and medical responsibilities of the physician; however, they greatly reduce the complexities of decision making in this difficult area.

Regis A. de Silva

See also Bioethics History of; Brain Death; Defining and Conceptualizing Death; End-of-Life Decision Making; Legalities of Death

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Personifications of Death

As a personification, death is portrayed as a person with human characteristics, in contrast to a functional description of death, such as "the end of life of an organism." The anthropomorphic features of death are represented in the physical appearance of death (e.g., a human skeleton) and the activities death is imagined performing (e.g., playing an instrument). In addition, death can be given a gender, clothing, personality, and voice. Personifications of death are representations of how humans imagine death. By personifying death, we reveal how we experience death, especially when death is given a particular character. In stories in which death is presented as a person, humans trick or play with death; this suggests that people want to be in control of their own deaths.

Personifications of death have been depicted in mythology, art, literature, and popular culture since 800 B.C.E. This entry overviews four themes to explicate the richness of the personification of death: (1) images of death in mythology and religion, (2) the gender of death, (3) modern images and motion pictures, and (4) the psychology of personifications of death.

Images of Death in Mythology and Religion

In Greek mythology death is represented by Thanatos, the god of death. Although Thanatos is a god, like other Greek gods, he has human attributes. He has a human body and is seen as the brother of Hypnos, the god of sleep. A classical image of Thanatos is a barely dressed man with wings who ends people's lives by a gentle touch. In this ancient representation, death is not cruel or frightening, but rather, a kind, inevitable visitor. The anthropomorphism in the illustrations of Thanatos is most visible in a painting by German artist Johannes Heinrich Tischbein, which shows the mother of death, Nyx (the goddess of the night), and her two little children, Thanatos and his brother Hypnos. In the image, the mother Nyx gently places her arms around her two sons.

In Hinduism, the god of death is personified in a human-like body, with a human face or a mask, in the form of Yama. A central attribute of this representation is a bull on which Yama is sitting or standing. The god of death holds a rope or a mace and pulls out the souls of those about to die. The gentleness in the image of Thanatos is not to be found in this personification. Moreover Yama brings justice to the world. A popular myth tells that Yama used to be a human who, just before reaching Enlightenment and after 50 years of meditation, was killed by two robbers.

Many images from the Middle Ages of *la danse macabre* (dance of death) are often combined with parts of texts from the Bible. The dance of death is a metaphor for the last struggle with death. In many images of la danse macabre, death is shown as a dancer, or more precisely, a dancing skeleton, sometimes wearing a robe or piece of cloth. Death also plays different instruments in different images, among others a violin, harp, or drum. In these images, death is touching people or pulling their clothes while showing his teeth, which gives the impression that death is laughing at his guests.

The Gender of Death

If death were a person, would it be a man or a woman? Personifications of death in Western cultures are mainly restricted to a masculine appearance, such as "the Grim Reaper," who wears a black robe and carries a scythe. In this image, death brings the message when someone has to die. However, there are cultures in which death is seen as a female. Female representations of death are often found in cultures where the word *death* is grammatically feminine, such as *la muerte* (Spanish) and *śmierć* (Polish). *La santa muerte,* the holy death in Mexico, is a female skeleton wearing a dazzling robe. In contrast to the sharpness of the scythe, she holds a bouquet of beautiful, colorful flowers and brings love, luck, and protection to the people. In exchange for the protection *la santa muerte* provides, pilgrims bring luxurious, hedonistic gifts, such as alcohol and cigars, to her altar. Worship of *la santa muerte* has been forbidden by the Catholic Church, but she continues to be worshipped by Mexican people.

In *The Young Man and Death* (1865), the French symbolist Gustave Moreau illustrated death as an attractive, young, and seductive woman with her eyes closed. Death stands behind the young man whom she wants to take with her. In French *la mort* (death) is a grammatically feminine noun, which fits perfectly in the symbolic use of death during late 19th-century art movements. In *Thanatos I* (1898) by the Polish painter Jacek Malczewski, death is a beautiful, gracious, young woman with a strong feminine body and long wings, dressed in a white robe. In Malczewski's and others' female personifications of death, she is often associated with the angel of death. Originating from the Judeo-Christian idea of a death angel, this image is also used in art to picture death as an attractive woman with wings.

One of the most famous and controversial images in history of a female angel of death is in the symbolist painting *Death of the Gravedigger* (between 1895 and 1900) by Carlos Schwabe. In this painting death is a female angel with long wings shaped as scythes, wearing a black dress that emphasizes her feminine body. The angel of death

crouches over a grave in a snowy graveyard. In the pit stands the aged gravedigger whose life is about to be taken away. Although death embraces strength and power in this image, she does not appear as a frightening figure, but rather, has the look of a gentle angel. In this image death holds a lit candle, a common symbol that indicates the approach of death. When the candle goes out, it is time to die. The left hand of the death angel points toward heaven, which can be interpreted as a promise for an afterlife.

Another important concept in the personification of death is the depiction of death as an attractive man—the motif of death and the maiden. Used in numerous illustrations, books, poems, and plays, the maiden is often seduced by death and her life taken by his temptation. Death is often depicted as having an erotic relationship with a (young) woman. The tense relationship between lust and death is reflected in paintings such as *Death and the Maiden* (1517) by Nicklaus Manuel, in which the hand of death is under the woman's dress. Matthias Claudius's poem "Der Tod und das Mädchen" describes the dialogue between death and a young girl. The girl is begging death to pass her by, but death answers that he is her friend and he will not punish her. "You will sleep peacefully in my arms" are his last words.

Modern Images and Motion Pictures

The transformation of the image of death is seen in the works of Gustav Klimt. He mixed symbolism in paintings with art nouveau, but his work was heavily criticized for its explicit reflection of the female body. In the oil painting *Death and Life* (1910–1915), Klimt depicts death as a vague bodiless robe with a skull and bony hands holding a mace. In contrast, life is illustrated in the shape of naked human bodies of men, women, and children who are lying together in unity. The intensive use of colors in this painting is significant, as life is represented in various light colors, while death is veiled in black and dark purple. Moreover, Klimt uses crosses on death's robe to link to the symbol of Christian graves.

With the advancement of new art techniques in the 20th century, death received a different face wrapped in old symbols. In *Dada Death* (1918), the artist George Grosz put on a skeleton mask and walked through the streets of Berlin. Here death continued to possess the typical face of a skull, but at the same time death smokes a cigarette and walks between humans. In the classic movie *The Seventh Seal* (1957), directed by Ingmar Bergman, death is represented as an older man in a black robe with a white face. In this emotionless personification, death appears as almost benign. A young warrior is able to delay the end by making death play chess, but he cannot escape his fate. Ultimately, death wins and takes a whole group of people to the final dance of death, evoking the image of la danse macabre. *Meet Joe Black* (1998), directed by Martin Brest, is a contemporary film in which death is personified. The American actor Brad Pitt plays a handsome and charming personification of death who falls in love with the daughter of the man slated to die. Death is presented as a generous fellow and gives the old man more time to say farewell to family and loved ones, without revealing his true nature to the rest of the world. Though classical symbols such as the skull are still used in modern images, in modern depictions, death possesses a more flexible and adjustable nature and is open to negotiation. These depictions of death reflect the human desire to control death.

The Psychology of Personifications of Death

In psychological research death has been studied from different perspectives. Robert Kastenbaum and Ruth Aisenberg (1972) identified four categories in people's personification of death. They asked respondents to describe death as a person. From the answers the following four characters were identified: Macabre, Gentle Comforter, Gay Deceiver, and Automaton. The Macabre views death as a frightening figure, whereas Gentle Comforter is a calm and nonthreatening personification. The Gay Deceiver is an illustration of death as tricky and tempting, and the Automaton is death presented as an unemotional and mechanical entity. This study concluded that most respondents described death as an older male with a gentle character, with second and third identifications of death with a cold attitude and death as a grim, terrifying character, respectively. According to Kastenbaum and Aisenberg's study, if death had an age and gender he would be around 60 years old and male. Other

studies also revealed that personifications of death are related to gender, death anxiety, professional association with death (e.g., funeral directors), and belief in an afterlife. Recent studies focus on death personifications and adolescent risk behavior. Nowadays researchers use standardized instruments in measuring death personifications, such as the Adjective Check List, which consists of 300 person descriptions and is mainly used in personal and social psychology. The research on death personifications can bring us closer to understanding the relationship between humans and their experience of death. Throughout history people have tried to build an image of death by attaching human characteristics. Whether it is fear or fascination that motivates us to create a picture of death, it certainly will not stop in the near future.

Joanna Wojtkowiak

See also Dance of Death (*Danse Macabre*); Depictions of Death in Art Form; Depictions of Death in Sculpture and Architecture; Depictions of Death in Television and the Movies; Symbols of Death and *Memento Mori*

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Photography of the Dead

Many Christian societies used the photographic method to depict the dead. Whereas this practice may now appear unusual, it had been in fashion from the 19th century to the beginning of the 20th century all over the Christian world. Such a phenomenon raises two issues. The first is the necessity to understand the sense and the social uses of these pictures in the social context of the period. Second is the desire to understand the causes of the disappearance of this practice. Indeed, the refiguring of the family structures and the waning of the importance of religion in the Western societies had a great impact on this practice. This means that the photography of the dead makes sense in a particular social context in which people used it to face the reality of death, then perceived through Christian cosmological ideals. The following discussion presents the association between this form of human experience of death and the social context within which it occurred.

The first part of this entry addresses the recourse to the photographic method to represent the dead in different Christian countries. Then, the discussion focuses on the process of idealization of the dead. Indeed, during funerals the social group creates an idealized memory of the deceased fixed by the pictures. Fixing this idealized memory, these pictures serve three main functions: (1) to create family ancestors, (2) to perpetuate the family identity, and (3) to enhance the process of mourning. Lastly, the phenomena responsible for the disappearance of this practice are discussed in order to present a more global perspective on the association between the photography of the dead and the social context.

Postmortem Pictures as Representations of the Dead

In keeping with the tradition of representation of the dead—which involves recumbent effigies, postmortem depictions, and mortuary masks—the photographic method was used in the 19th century in order to depict the dead. This medium was initially used by painters as a model for the postmortem painted portraits, but photographs progressively became actual representations of the dead. Indeed, the photographic method had major advantages in that pictures were considered faithful reproductions of reality, were infinitely reproducible, and were affordable. Whereas the postmortem portraits were initially intended for the rich and public characters, the appearance of the photographic method allowed a complete democratization of this practice.

Deceased person lying in state, Poland, 1967

Source: Nadine Mielzareck. Used with permission.

Postmortem pictures mainly consist of taking pictures of the deceased lying in state, or of the entire funeral, including the deceased lying in state, the mass, the procession, and the inhumation (see photos). Nevertheless, pictures are found in which dead children are represented in a state of sleep. Indeed, the parents who lost a young child but did not take a picture of him or her when living could, through this medium, still have such a memory in which the death does not appear so obvious.

As with other means of representing the dead, postmortem pictures are associated with Christian conceptions of death. They can be considered as an expression not only of the *ars moriendi* but also of the belief in resurrection. According to this belief, each individual is composed of a body and a soul which are separated after death but which are supposedly reunified after the Last Judgment. In this view the corpse represents strong meanings and the postmortem pictures make sense. Each picture is not only a representation of a deceased person but also a representation of an individual.

The correspondence between Christian conceptions of death and the postmortem pictures explains why these were generally accepted in Christian countries. During the 20th century, this practice was in use in Mexico, Peru, Argentina, the United States, and all over Europe, including in France, Spain, Italy, Denmark, Poland, Hungary, Bulgaria, and among Christian Ghanaians.

Used in different ways, the pictures could be distributed among the relatives, fixed on a brooch or on a pendant, kept in a special jewel-case, placed on the fireplace, hung up on the wall, or fixed on the grave. These pictures could also be placed in family albums among pictures of baptisms, communions, and weddings. In this case, they work as a family archive, which fixes the family history.

Postmortem Pictures as Idealized Images of the Deceased

It is important to consider the practice of postmortem pictures in a more global perspective. Whereas today people take pictures of everyday life, in the past pictures were taken during extraordinary and collective events, such as baptism, communions, weddings, and funerals. Thus, taking pictures solemnized and eternalized the major events of concern to the social group. These events were important because each displayed a change of status and refigured the social structure. Indeed, a baptism integrated an individual into the Christian community, the communion integrated teenagers among the adults, the wedding integrated a new family into the community of families, and the funeral integrated the deceased into the world of the dead. In other words, these events are representative rituals of passage and transition from one status to another.

During these events the social group behaves as if it were on stage and displays an idealized image of itself. Thus, photography as nonverbal text fixed this social ideal. When placed in family albums, the pictures work as archives telling the family and group story, as a storyboard may do, by figuring the major stages of the collective life.

The postmortem pictures are considered a part of this process. Indeed, according to Christians, death is not a rupture but a transition from one state to another. It is the last stage that ends the earthly life cycle. And, the funeral creates an idealized image of the deceased. The manner of dress, the quality of the coffin, and the quantity of mourners and of religious symbols ideally demonstrate one's social status and adherence to the group's social values.

Thus, the ritual and postmortem pictures cover three main dimensions: cosmological, social, and individual. Indeed, by creating a collective memory of the deceased, the social group reaffirms its unity weakened by the loss of one of its members, but it also reaffirms the continuity between the earthly and the life after death. This memory and this continuity are also means to face the distress caused by death. Thus, the deceased do not disappear but continue to live from beyond the grave. They are supposed to live closer to God and in the memory of the living. The fact that postmortem pictures cover cosmological, social, and individual dimensions leads us to attribute to them three major functions: ancestralization, family integration, and the trace.

Procession leaving the church, Poland, 1967

Source: Nadine Mielzareck. Used with permission.

Inhumation, Poland, 1967

Source: Nadine Mielzareck. Used with permission.

The Functions of Postmortem Pictures

Ancestralization

An ancestor can be defined as a divinized dead person. In the case of family ancestors, families are involved in a system of allegiances. They have the duty to care for the memory of their ancestors and to satisfy their expectations by rituals, prayers, and the respect of taboos. An unhappy ancestor can cause damage to the living. Those who are living hold expectations of their ancestors as well. Indeed, if they encounter a problem, the living can ask the dead ancestor for help. As Jean Baudrillard states, dead and living are both involved in a process of symbolical exchange. In anthropology, a distinction is made between societies with a cult of ancestors (as in China, Madagascar, and some African countries) and societies with a cult of the dead (as in Western and Christian countries).

The case of Poland shows this distinction. Polish Christians think they can help the dead by praying for the raising of their soul, whereas the Christian dogma states that everyone is judged according to his or her acts. But Polish Christians also think they can expect help from the dead. In this perspective the dead are considered as ancestors in a Christian society.

In this context, postmortem pictures can be considered as representations of family ancestors. By expressing their adhesion to cosmological values with religious symbols and objects, the suggestion is that the deceased will join God and the Saints and will, from this affiliation, be more powerful.

"Dead baby lying on a bed covered by fur, his head on a pillow" by Kasimir Zgorecki, Polish community in France, around 1930.

Source: © ADAGP, Paris, 2009. Used with permission.

Family Integration

Embodying the family social background and the social ideals, postmortem photographs function as an important identity reference for a family. Indeed, albums are generally consulted during family meetings and promote the transmission of family memory and identity. By expressing their allegiance to an ancestor, family members not only reaffirm their links but also their common identity. Simultaneously, the awareness of its social identity allows a family to preserve its position among the social group.

The Trace

The function of trace has psychological meaning. Indeed, postmortem pictures function as *transitional* objects, meaning that they support the transition between an external reality and an internal one. The process of mourning works in a similar way. First, mourners have to awake to the consciousness of an external reality—the death of somebody—and then internalize progressively the relation with the deceased. Thus, by showing the reality of death and by supporting the memory of the ancestors, postmortem pictures can be considered good media for the transition between the acceptance of the loss and the perpetuation of the internal relation with the deceased.

In contemporary experience postmortem pictures are less fashionable. Although still in use in countries such as Ghana, the Western countries have, since World War II, all but abandoned this practice. Secularization, urbanization, individualism, and professionalization of the funeral field are the major phenomena that account for this change. Indeed, secularization causes a distancing from religion and Christian conceptions of the corpse and of what happens after death. Simultaneously, urbanization implies new legislation based on public health concerns and intensifies the focus on individualism, and so religious and social networks of solidarity become diminished. The families in grief, who were previously supported by these networks, are also more isolated. This social isolation explains in part why families request funeral firms to organize the funeral. Thus, whereas the corpse was previously a ritual object, a critical component of the social and religious dimensions, the funeral now takes on a more profane characteristic managed by medical personnel and undertakers. As postmortem pictures made sense because the corpse was considered a sacred object, the corpse's involvement in a professional dimension explains the irrelevance of postmortem photos in modern societies.

Emilie Jaworski

See also Art of Dying, The (*Ars Moriendi*); Death Mask; Depictions of Death in Art Form; Depictions of Death in Sculpture and Architecture; Funerals; Soul

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Popular Culture and Images of Death

Western society is normally described as a death-denying culture; death is seldom discussed in an open, forthright manner. Rather, euphemisms for death and dying are employed, and the topic has been characterized as taboo or even pornographic by some observers. People also attach fearful meanings to death and dying. However, citizens simultaneously seem to have an almost fanatical attraction to death-related phenomena. Since people are generally insulated from personal experience with death and dying, they regularly seek information on these phenomena. For instance, images of death, dying, and the dead occupy a prominent place in popular culture and regularly appear in various entertainment and information media. Popular culture, which is a core part of collective existence, both reflects and influences death-related attitudes. Although thanatological themes have historically occupied an important place in Western popular culture, with the advent of new technologies such as the Internet and satellite television, cultural space is even more saturated with these death-related images.

Print Media

Thanatological themes play a major role in the printed media; books about war, crime, and mysteries have been exceptionally popular. However, with the advent of photojournalism, graphic images of death and dying are especially prominent in the print media. Stories about these topics, frequently accompanied by attention-grabbing headlines, often appear in newspapers. Yet, newspapers usually only portray particularly catastrophic, ghastly, and spectacular causes of death. One notable exception is the obituary, which often includes a photograph of the deceased individual.

Death-related images are also prominently featured in many popular news magazines such as *Time, Newsweek,* and *U.S. News & World Report.* Such publications often contain color photographs of the terrible devastation of events such as the September 11th attacks and Hurricane Katrina, as well as gruesome pictures of the victims of war and genocide. Perhaps the most extreme example of this phenomenon is the supermarket tabloids. These publications, with an estimated weekly readership of 50 million people, include articles about accidents, murders, and life-threatening celebrity health scares, as well as features about near-death experiences, ghosts, body disposition, and reincarnation.

Cinema and Television

Death and dying are also a very important part of many genres of cinema. Examples include movies about war, westerns, and dramas. Others include films about accidents, disasters, terrorism, and extinction level events (e.g., a meteor striking Earth). There have also been comedies featuring these topics, such as *Weekend at Bernie's* and *Dead Man on Campus.* Horror films have traditionally been, and continue to be, wildly popular with a significant segment of the population. These include movies about killers, monsters, and zombies, as well as thrillers. The "slasher films" of the 1980s such as *Halloween, Nightmare on Elm Street,* and *Friday the 13th* were exceptionally popular. The horror movie is experiencing a resurgence in recent years, as evidenced by the success of ultraviolent films such as *Saw* and *Hostel.*

Television viewing is an important aspect of the recreation and leisure activities of the masses. Death, dying, and the dead are prominent motifs in much of contemporary television. These are the central themes of many of the most highly rated prime-time television programs, including crime dramas (e.g., *CSI: Crime Scene Investigation* and *Law & Order*) and medical dramas (e.g., *House,*

Grey's Anatomy, and *ER*). These topics are also featured in a variety of other types of television programs. Examples include soap operas, mysteries, documentaries, children's cartoons, and reality shows. These topics are even a mainstay in religious television programming.

In contemporary society, news and entertainment are frequently combined into "infotainment." Televised news coverage has taken on a new, and even more influential, dimension because of the global reach of satellite broadcasting and 24-hour cable news outlets such as SkyNews, CNN, FOX News, and MSNBC. Accordingly, the news media plays an integral part in the transmission of knowledge and information to the general public in the new millennium. Contemporary televised news media are saturated with images of death, dying, and the dead. In times of tragedy, disaster, and crisis, people turn to media outlets for information and these traumatic events in turn become media events. For instance, the funeral of Princess Diana was seen by an estimated 2 billion people worldwide. In turn, the media assist in framing these events in ways that affect how people subsequently attach meaning to these events. Consequently, for many people, the media coverage of these situations becomes the reality, and critics express concern that it is becoming increasingly difficult to distinguish between the actual reality of a situation and the media portrayals of the reality of that situation.

Music

Death and dying have been pervasive themes in popular music as well. These motifs are especially common in contemporary forms of music, particularly rap and heavy metal. However, death-related imagery has become even more influential inasmuch as televised media have added an additional outlet for the dissemination of these thanatological images associated with this music. One prime illustration is the music videos that appear on television networks such as MTV, MTV2, and VH1. These music videos often feature scenes relating to homicide, disasters, accidents, illnesses, and afterlife concerns. In fact, one of the most popular music videos of all time, "November Rain," by Guns N' Roses features a funeral. Live musical performances that regularly appear on broadcast events such as *The Grammys* and the *MTV Video Music Awards* also feature songs with death-related themes. Examples would be performances of "Murder Was the Case" by Snoop Dogg (a song about homicide charges) and "Stan" by Eminem (a song about a murder-suicide). Arguably the most striking example of this was Elton John's performance of the song "Candle in the Wind '97" at the funeral of Diana, Princess of Wales. This ballad, which was among the best-selling and most successful songs of 1997, was an adapted version of the artist's musical tribute to deceased motion picture icon Marilyn Monroe.

Internet

The Internet revolutionized social life, and it now occupies an increasingly influential place in popular culture. As a medium for communication, the Internet transcends geographic, political, and social boundaries. Images and videos, even those taken by a mobile phone, can be instantly disseminated and viewed worldwide. One recent example is the video of the execution by hanging of Saddam Hussein. The Internet is fraught with thanatological content. For instance, there are a variety of virtual memorials to the deceased, and some individuals have blogged (including photographs) their battle against terminal illnesses such as cancer. However, some of this content is far more graphic in nature. One site, called "The World of Death," boasts a large collection of death photographs, including crime scenes, accidents, suicides, executions, and beheadings. There are dozens of similar websites. Some of this death-related content is political and controversial. For instance, members of jihadist terrorist groups post videos of their attacks and beheading of hostages, as well as videos of the last public statements of suicide bombers. The death-related content of the Internet even assumes some configurations that are humorous in a convoluted fashion, such as celebrity dead pools and web pages dedicated to dead celebrity jokes.

Dead Celebrities

Images of dead celebrities occupy a special place in postmodern cultural space. The notoriety of some of these individuals has assumed a pseudoreligious

dimension in contemporary society, sometimes referred to as "symbolic immortality" (i.e., a person's meaning lives on after she or he has died). Examples include Elvis Presley, James Dean, Marilyn Monroe, Mother Theresa, Bruce Lee, Tupac Shakur, Jim Morrison, Ernesto "Che" Guevara, and Kurt Cobain. However, the best illustration of this phenomenon in recent years is the case of Princess Diana. Following her tragic death she was memorialized in a number of ways including songs, videos, web pages, stuffed animals, books, towels, ashtrays, and stamps, to mention but a few. In essence, through images in popular culture, deceased public figures such as Princess Diana continue to exist in the minds of the living.

The Death and Dying Paradox

Sociologists note that a culture's death-related practices and beliefs are linked to the social organization of society. On the one hand, contemporary society is characterized as a culture that systematically denies death and dying. On the other hand, there is an obsessive fascination with thanatological topics that is manifested in the presentation and consumption of death-related images in popular culture. These images are essentially cultural products that simultaneously reflect and influence attitudes about death, dying, and the dead. One possible explanation for this apparent paradox may be that the United States may not be the death-denying society as some analysts allege. However, the fascination with death-related phenomena could also be interpreted as a manifestation of death denial. The saturation of cultural space with thanatological images may desensitize people and thus reduce viewer anxiety about death and dying. In popular culture, death-related phenomena may be presented as fascinating, exciting, entertaining, and even humorous. The sensational images of accidental, violent, and otherwise gruesome deaths may even result in a convoluted type of voyeuristic pleasure for some people, such as the "accident watchers" in the population. Through the reconceptualization of death and dying, the traumatic nature of these events can be socially neutralized. The appreciation of these images also necessitates some degree of detachment, thus further insulating the individual from such death-related anxieties. Even though we are saturated with these images, we rarely view actual corpses.

These images of death, dying, and the dead have been, and most likely will continue to be, the source of a great deal of social controversy. Advocacy groups, as well as medical and mental health professionals, have criticized the amount of violence in television and movies. There are concerns that this may desensitize young people to death and dying, as well as possibly serving as the catalyst for real-life violence. Similarly, popular music, especially "gangsta rap" and "heavy metal," are also criticized. Because these cultural artifacts sometimes include eschatological images of demons and hell, this has drawn the ire of religious and social conservatives. Video games have also been condemned for the portrayal of violent death. With the increasing popularity of new media such as the Internet, the presentation of graphic images of death and dying with continue, if not increase, in frequency. The attendant social controversy is destined to continue.

Keith F. Durkin

See also Memorials; Symbolic Immortality; Video Games

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Pornography, Portrayals of Death in

Portrayals of death in pornography depict the juxtaposition of sexuality with death. Although much literature includes the topic, the representation of death in pornography is relatively rare, as pornography constitutes intention on the part of the pornographer to induce sexual arousal. The understanding of portrayals of death in pornography and its definition are related to whether the material in question is appealing to prurient interests. This entry addresses these issues within the context of changing social mores and the evolving definition of pornography as it portrays death.

The Context of Pornography

Some contemporary media link death with pornography but as separate and distinct elements. Some Internet websites, for example, provide short film footage and claim extremity and perversion. Content does not reveal death and pornography evidenced in the same films. Rather, films of death and films of pornographic representations are offered as distinct film foci. A portrayal of death in pornography may be a fictionalized representation or a depiction of an actual occurrence of death. In the case of pornography, either representation constitutes a portrayal of death.

Arousal from pornography may be physical or psychic. Thus, to arouse sexually does not necessarily require a physiological arousal and may be entirely psychically focused. Alternatively, the intention to stimulate sexually may be unsuccessful in some individuals. But if the text is defined as pornographic in that it is designed and created with the intention to sexually stimulate the observer, the failure to sexually stimulate in some observers does not change the initial intent of the pornographic text.

Pornography is designed to stimulate the mind into considering a possible sexual activity or relationship. Portrayals of death in pornography may personify what Sigmund Freud referred to as the drive of *thanatos*, the "death" drive. Freud postulated that there were two distinct forces in the human psyche: libido, or the life drive, and thanatos, the death drive. Both instinctual drives are theoretically antagonistic to each other. Freud observed regular though infrequent variation away from what he assumed was a "normal"' sex aim: namely, reproductive heterosexual dyadic coitus in humans. Such variation may include gender or object variants. Other analysts have suggested that Freud's concept of sexual libido may be channeled toward any object, thereby rendering obsolete the idea of a "normal" object onto which libidinal energy attaches. The implications move from a "normal" singular focus of libido within a sexualized arena to a diversity of libidinal objects, situations, spaces, and relations.

Pornography as a text is intended to induce sexual stimulation. If one keeps in mind the flexibility of libidinal object, it may be addressed using a variety of subjects. In this regard, the possibility of the eroticization of death becomes understandable as one possibility.

Attitudes and actions in response to death are culturally specific and significant taboos surrounding death and sexuality in most cultures. Pornography may be received as a text that is intended to be sexually stimulating, or it may be read as a vehicle to instruct the novice in the realm of sexuality. For this reason pornography is often regarded as dangerous for those involved in the production of pornography as well as for the consumer.

Some feminist thinkers raise concerns with pornography that depicts women violated in violent situations, as objectified and adjunct/accommodating/subservient to male sexuality and sexual satisfaction. Much of the feminist critique has centered on the notion that women are degraded in the sexualized heterosexual depictions. Sadomasochistic representations of pornography, which frequently include the death of the submissive female, also have generated concern among feminist analysts. Such critical arguments are based on structural power imbalances made obvious in sadomasochistic heterosexual pornography, which instructs men, the predominant users of pornography, to maintain power imbalances between the sexes.

The Marquis de Sade penned a number of texts that included portrayals of death within the pornographic content. Writing in the mid to late 18th century, de Sade's texts were designed to excite sexually and were received as such. His writings outraged the political power of the time but were eagerly received by the general public. De Sade's depiction of death is resultant from overt acts of murder as well as the

engagement of activities that inadvertently end in death, though these outcomes occur through deliberate engagement in sexual activities.

De Sade's *120 Days of Sodom* is a pornographic work that details a clandestine location wherein "friends" and "libertines" engage in largely nonconsensual sex. De Sade's fictional pornographic accounts include many descriptions of mutilation resulting in death, and he outlines a variety of sexualized acts that induce horror and revulsion. The metaphor of a clandestine location in de Sade's text may reflect the intellectually clandestine location of the ideas presented, ideas that may be understood as part of Western sexuality. The sexualized universe represented within de Sade's work gestures toward a disordered portrayal of human interaction that stands in marked contrast with the "rational," ordered universe of the Enlightenment.

Andrew Sherwood

See also Autoerotic Asphyxia; Sex and Death; Sexual Homicide

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Posthumous Reproduction

In Western culture, the practice of creating a likeness of an individual's face and/or body after death through media such as photography, drawing, painting, wax, or plaster can be traced back to at least classical antiquity. These images of ordinary individuals as well as the rich and powerful had a variety of overlapping functions. They reminded the living of the brevity of life, provided a record of death, preserved the features for posterity, and assisted in the rituals of grief and mourning. Although the practice waned considerably in the early decades of the 20th century, it has revived in recent years.

The "death mask" is perhaps the oldest method of preserving the features of the deceased. An exact copy of the face was made by covering it with plaster or wax and allowing it to harden thus creating a mold. A "mask" or bust could then be prepared from this mold. In Roman culture wax masks, called *imagines,* made from death masks of the deceased were displayed in the home and used in funeral rituals. The masks were important particularly for the patrician classes as they established the lineage of an individual, separating him from the lower classes below and those of wealth and power with less established ancestry. When a member of the family died, hired actors would wear the masks and march in the funeral procession, reviving not only the likenesses of the ancestor but also reviving his virtues as well.

The use of death masks continued into the medieval and Renaissance eras during which time they were also used as aids for sculptors creating tomb effigies for the aristocracy and for the lifelike funeral effigies for the lying-in-state of monarchs and other national figures. The best preserved examples of these effigies are in Westminster Abbey. The bodies of these figures were often fashioned of wood, or leather stuffed with hay, with faces and hands made from plaster, wood, or wax. The features were painted or tinted with added facial hair and eyelashes to appear as lifelike as possible. Often dressed in the deceased's own clothing, the effigies provided not only a facial likeness of the dead, but a reproduction of the entire body around which appropriate mourning rituals could be performed as the effigy would not suffer the physical corruption of the deceased's actual body.

Death masks continued to be made well into the 19th century affording posterity with an opportunity to look into the faces of the famous, such as Walt Whitman and Frederick Chopin, years after

their deaths. The masks could also provide more ordinary families with comfort and solace in their grief. Although the practice of making death masks seems to have waned in the early 20th century, it has made a resurgence in recent years as British artist Nick Reynolds and groups such as the Association of Lifecasters International in Summit, New Jersey, continue to receive requests for the masks.

In addition to the death mask, painting and drawing were also popular methods to preserve the likeness of the recently deceased and examples survive from at least the 15th century. These images served a variety of functions. Paintings such as John Souch's *Sir Thomas Aston at the Deathbed of His Wife* (1635) record not only a specific death but also depict the family's mourning, demonstrating their love and participation within accepted societal codes of grief and mourning. Drawings not only recorded the physical features of the deceased for the family, but they also could be used as a model from which the artist would fashion a painting showing the deceased as if alive, such as Ralph E. W. Earle's portrait of Sarah Louise Spence, circa 1833. Although Earle clearly depicts Sarah looking out at the viewer, he communicates the young girl's true state by depicting her holding a rose cast downward, a symbol of a young life cut short.

When photography was invented in the late 1830s it, too, was employed as another medium in which to create postmortem images. Because it also quickly became a relatively inexpensive way to capture a likeness, photography made it easier for families of almost every class to have a last image of their loved one. Although most postmortem photographs are of children, there are a significant number imaging adults as well, and photographs survive from almost every social stratum from the British monarchy to working-class families in America. Children were often photographed being held by parents and siblings or tucked into their beds, their limbs arranged to mimic sleep. The tension between the semblances of life and death were further obscured as many families requested the child's eyes be opened and the body propped up to appear sitting and or holding a favorite toy. While these images often appear gruesome to modern viewers, there is numerous testimony in 19th-century diaries and letters attesting to the great solace and comfort these images provided for the grief-stricken families. More recently, collectors have become fascinated with postmortem photographs, and the numerous websites on the Internet and texts written about them have made the practice more widely known to the general public. While the actual practice of taking postmortem images, like that of death mask, also waned in the early 20th century, postmortem photography has more recently been adopted for use in hospitals to assist families through the grief of a stillborn child.

Terri Sabatos

See also Death Mask; Photography of the Dead; Symbols of Death and *Memento Mori*; Wax Museums

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POSTSELF

The postself is who one is in the minds of others after you are dead. It is one's postmortem reputation; it is how one is remembered; it is one's place in human history. Many individuals, while they are living, have a considerable investment in their postself reputation. The concept of the postself casts a rather wide net, dealing as it does, by implication at least, with the issues of afterlife and hereafter, life-after-death heaven, reunion, resurrection, angels, saints, and god. On the other hand, it is limited to the thoughts and aspirations of living persons, living in a here-and-now world.

For some, the positive postself can be an important goal of life. To have one's memory live on or

to have a participative future in the world yet to come can be of vital importance. The desire may not be legendary, like Mozart or Lincoln, but rather an extension beyond the date on one's tombstone.

There are various ways in which an individual can continue to live on after death. First, and perhaps most importantly, in the memories of others. In life one can make his or her actions count or, just by being, capture the interest and concern of others. Second, there is active stimulation of others through one's works, such as art, music, and writings. A third means is through the use of a legal document, such as a will or directive, in which a living person seeks to control the behavior and welfare of others through what is essentially a system of punishments and rewards.

Yet a fourth means through which one can continue to live on is through suicide notes. Such notes represent a crucial extension of the self beyond death, and these documents often are replete with absolutions, accusations, and exhortations. The suicide note can be a powerful, impactful document through which the postself lives on.

The fifth way the postself is guaranteed is within the body of another person through organ transplantation, either from a living donor or from a cadaver. Thus, one's postself is achieved through the use of body organs or perhaps body parts.

The postself is assured yet a sixth way in the genes of one's children. Indeed, genetics assures that there is biological immortality. Genetic inheritance lives. DNA seems almost infinite. There is an immortal chain of living things. Philosophers write about "generativity," that egotistical hope that one's children and grandchildren might carry on one's work after death puts an end to one's efforts, that they will supply biological escape from death. One becomes a part of the whole stream of human existence with an overflow into an unknown future.

Finally, philosophically, one may achieve a postself through the cosmos. One must try to live as if one is immortal and as if society is eternal, knowing that both assumptions are false. But each must be accepted on faith if one is to believe one will continue to live through the postself.

To cease as though one had never been, to exit life with no hope of living on in the memory of another, to be expunged from history's record. For some individuals this may be a fate far worse than death. Only a feral child or a deeply autistic person might not be capable of conceptualizing a postself.

If one is fortunate enough to live a long life, his or her heart muscles will beat several million times a day. Little more in life is certain. That is why living thoughts of oneself after death can be psychologically important. Herman Melville, arguably one of America's greatest novelist, was right on the mark when he wrote to his friend Nathaniel Hawthorne (in June 1851) that he would be unknown in his own century but that he wrote for a posthumous glory to come. Melville's investment was in his postself.

Edwin S. Shneidman

See also Deviance, Dying as; Immortality; Symbolic Immortality

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Pre-Need Arrangements

Pre-need funeral arrangements are the practice of organizing and paying for funerals prior to death, and usually while the purchaser is in (relatively) good health. A term used interchangeably with *pre-pay funerals*, *pre-need arrangements* are part of a wider expansion of consumer choice and individual empowerment in bereavement services. Comparable practice can be found in the development of living wills and patient-centered end-of-life decision making. As a source of income generation, they also form part of a broader commercialization and commodification of the funeral directing industry, whereby funeral providers have become increasingly entrepreneurial and consumer oriented.

Profiling Pre-Need Planning

Not much is known about those who purchase pre-need plans, but research evidence suggests that those who purchase pre-need arrangements tend to be older, more educated, and more religious than

those who do not. It was estimated in 2003 that over a third of all American funerals had been paid for, at least in part, in advance.

While there remains much to be learned about the uptake of pre-need arrangements, much more is known about the business features of pre-need arrangements. In their summary of pre-need arrangements in 1995, Mercedes Bern-Klug, Stanley DeViney, and David Ekerdt found that the cost of pre-need arrangement in the United States ranged enormously, between $195 and $14,000. Such disparity in cost they attributed to the varying fees charged for body disposition—burial, in particular, tends to be more costly than cremation. This range of charges for pre-need arrangements indicates that they are a profitable source of income for plan providers.

As a tangible example of a growing commercialization of death, there are concerns about how pre-need arrangements are regulated and monitored, and the extent to which funeral guarantees are upheld. On the other hand, however, proponents of pre-need argue that they offer choice and flexibility, and enable the individual to leave specific instructions as to what they want to happen after they have died.

Often marketed as providing "peace of mind" in offering the consumer reassurance that provision will be made for their funeral costs and that their wishes will be adhered to, the origins of pre-need arrangements can be found in formal state funerals, in which the funeral was arranged, usually with the agreement of the figurehead, prior to his or her death. The idea that a funeral is paid for before the individual has died also bears similarities to 19th-century burial clubs in North America and the United Kingdom, where individuals paid a weekly fee to cover the cost of their funeral and burial. Pre-need arrangements became popular toward the end of the 20th century as large conglomerate companies began purchasing and operating funeral director chains, and recognized that pre-need arrangement plans not only were feasible in their provision but also were an ongoing and reliable source of income.

Pre-Need Option Payment Plans

According to the National Funeral Directors Association in the United States, there are three ways of arranging and paying for a pre-need funeral plan. First is the option of paying into a trust fund, which is usually arranged through a funeral director, a cemetery, or a private company. In this option, a percentage of the money invested is set aside for the cost of the funeral itself and the remainder becomes available for the use of the trustee at his or her discretion. The second option for a pre-need arrangement is available through insurance companies in the form of an insurance policy. These policies cover the cost of the funeral in the event of the policyholder's death. The third option for pre-need is setting up a savings fund for the explicit purpose of paying for a funeral, which is also referred to as an account payable on death, or POD.

The Funeral Industry and Pre-Need Planning

Pre-need arrangements were initially met with an initial resistance from funeral directors. This was because they thought that, in their experience, people were prone to purchasing more in emotionally charged situations. Arranging and paying for funerals in pre-need conditions was, therefore, seen as undesirable as the customer would most likely be calmer and purchase less. These early concerns reflect the continuing tension between providing an empathetic bereavement service and making a profit. Nevertheless, funeral directors' fears were alleviated by two reasons: First, pre-need arrangements have consistently sold well among pre-need populations and have been adopted as a part of the ever-expanding insurance industry. Second, the bereaved are able to "top up" funerals after the death of a pre-need policyholder. Conversely, this capacity for the bereaved to alter the arrangements made by the deceased policyholder suggest that some, if not all, of the planholder's arrangements can be overridden after he or she has died—an issue of great unease for those concerned about how pre-need arrangements are sold and regulated.

Common Features of Pre-Need Option Plans

In general, there are common themes throughout most plans, unless the pre-need arrangement is simply the provision of funds with no accompanying

explicit requests. Most plans cover advice for the bereaved on the certification and registration of a death, the cost of fees payable to doctors and clergy, care of the body prior to disposition, and the charges for the disposal of the body. Beyond these, the consumer also has a wide range of choices to make with regard to the level of coverage the plan provides and the format, structure, and content of the funeral service. The pre-plan customer can choose the available merchandise, which includes the casket, outer burial container (vault or grave liner), urn, register books, acknowledgment cards, memorial flowers, and clothing facilities. They can also choose how their memorial service is conducted; the vehicles for use in the service, such as a hearse and/or limousine; the cemetery plot and/or other charges; the equipment and staff at the graveside; and the forwarding and receiving of remains. Customers have the option to be very specific in their requests, such as "a mahogany casket with the Last Supper on the upper inside lid," or provide more general requirements, such as a "medium-range coffin/casket."

Supporters of pre-need arrangements point to how choosing from this selection of options when in a calm state of mind ensures that individuals can truly exercise their freedom of choice and ensure that they get what they desire. In addition, individuals have the time and opportunity to shop around for their pre-need plan of choice, enabling them to make an informed decision. Proponents of pre-need also point to how arranging and paying for a funeral prior to death can take pressure off the bereaved in having to make decisions and ensure that there are funds available for the funeral and bodily disposition.

Pre-Need Consumer Advocacy

In the United Kingdom, the Natural Death Centre actively promotes pre-need arrangements as part of a practical, hands-on approach to death and dying. As an option that enables the individual to decide the conduct of activity after their death, the Natural Death Centre contends that pre-need arrangements offer the individual a degree of control over how their body is treated, how they are disposed of, how they are mourned, and how they are memorialized. Pre-need plans can thus encourage individuals to contemplate their mortal condition. As a result, they are viewed and promoted as part of a healthy and responsible attitude toward death. In this vein, pre-need arrangements also suggest there is a contemporary openness about death, one which sharply contrasts with the popular view of death being taboo or denied.

Reservations have been expressed, however, as to the commercial features of pre-need arrangements. Aggressive marketing of pre-need plans, and the possible exploitation of vulnerable populations, such as the elderly or chronically ill, is a concern. It was estimated by the American Association of Retired Persons in 1999 that 43% of Americans age 50 and older had been solicited by pre-need plan providers.

Further concerns have arisen about how pre-need arrangements are upheld. Sometimes the bereaved are able to "top up" the funeral after the policyholder has died. Not only does this suggest that the bereaved can override the deceased's wishes and the policyholder's requests may not be guaranteed by the plan provider, it also indicates that there are possible loopholes in providers being able to charge more in the event of the policyholder's death. Indeed, if insufficient funds were set aside for the funeral, then the provider may well *have* to ask for more. Thus, consumers need assurances that enough money will be available to cover the funeral and disposition costs in the event of their death. The pre-plan policyholder also needs to be assured of what happens in the event that the provider is no longer in business when they do eventually die.

Shopping for the Right Pre-Need Plan

When shopping for a pre-need plan, customers need to consider a range of issues, particularly the way the policy is guaranteed. Customers also need to consider what happens to the policy, should they move, and the security of the money they invest in the scheme. They need to be aware of any refund policy that exists with the plan or how—if at all—they may make alterations to their specified choices. Moreover, policyholders must inform someone of the existence and location of their plan, as it is not unheard of that the next of kin are unaware of a pre-need arrangement—or cannot find it—and arrange the funeral themselves. Finding a plan after a funeral has taken place may cause a great deal of distress for the bereaved.

Framing all of these concerns is one of the key issues surrounding pre-need arrangements: the monitoring of providers. In the United States, the National Directors Funeral Association has written a bill of rights for funeral preplanning; in the United Kingdom approximately 90% of providers are monitored by the Funeral Planning Authority and their code of practice. However, both of these documents are voluntary agreements and offer little statutory protection. With little recourse, consumers therefore need to be fully briefed and aware of the consequences of taking out a pre-need plan. If they are in a vulnerable position, such as being recently bereaved themselves, customers may not be able to make a fully informed decision—which is when concerns about aggressive marketing can particularly arise.

Yet, despite these wide-ranging and legitimate concerns over the regulation of pre-need funeral arrangements and the possible exploitation of vulnerable populations, it is important to recognize the value of pre-need arrangements for those who wish to organize their own funeral. Much like living wills and advance directives, pre-need arrangements offer individuals the opportunity to decide what happens at their funerals and to delimit how much is spent. Nonetheless, to ensure these wishes are adhered to, and in a growing climate of litigation, pre-need plan providers are required to supply clear and concise terms and conditions, and there is a need for coherent and consistent regulation of all providers.

Kate Woodthorpe

See also Commodification of Death; Funeral Industry; Funeral Industry, Unethical Practices; Living Wills and Advance Directives

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Prison Deaths

Prison deaths remain one of the most poorly researched and documented areas in the social sciences. In no small part this is due to the "total institution" nature of prison facilities and their staffs and the concomitant secrecy that surrounds any death in that environment. Also, there has long been a tendency to use a narrow range of medical categories to define prison deaths; this narrow range of categories serves to obscure the actual causes in many cases. But prison deaths should include all cases wherein an inmate dies, regardless of the location or cause of death. In addition, terminally ill prisoners who are released as a gesture of mercy (or economy) should be included, as well as escapee prisoners who have died. In general, prison deaths include those due to homicide, suicide, and natural causes.

The difficulty of acquiring useful data on prison deaths is considerable under the best of circumstances, and once outside the economically and politically developed countries the problem becomes almost insurmountable. Considerable efforts have been made in recent years, especially by the United Nations, to fill in the blanks, but many gaps remain.

General Considerations

As a general rule, nations that are high-income or at least have significant elements of functional democracy are open in the reporting of prison deaths. Such nations have experienced a decrease in the number of deaths related to suicide and homicide but report an overall increase in prison deaths as a result of an aging prison population. This latter finding reflects the demographic trend of aging found in the larger population.

A common finding is that mortality rates in prison (all cases) are generally lower than those found in the general population. In the United States between 2001 and 2004, for example, the annual prison mortality rate of 250 per 100,000 was 19% lower than the mortality rate in the American population. The vast majority of prison deaths in the United States are due to suicide, homicide, and consequences of an aging population. In the period 2001 to 2004, inmates age 45 and older made up only 14% of the American prison population but accounted for 67% of all prison deaths. Chronic diseases such as heart disease (27%), cancer (23%), and liver disease (10%) accounted for most of the mortality among this older group of inmates. Many prison systems have begun to adapt to an aging inmate population by providing hospice for inmates who are terminally ill. The substantial drop in rates of suicide and homicide in the United States between 1980 and 2003 is noteworthy: The rate of prison suicides fell by 64%, and the rate of prison homicides fell by 93%.

In Canada, while the general tendency has been a decrease in suicide and homicide and an increase in mortality due to aging, there was one notable exception. In the late 1990s, the prison mortality rate for provincial institutions was 211 per 100,000 people, well below that of the general population. In the federal institutions, however, suicide was elevated and helped produce a mortality rate of 421 per 100,000, which was well above that of the general population of Canada. Much of the rise was due to the practice in Canada for inmates with longer sentences to be sent to the federal rather than the provincial institutions, a practice that led to elevated levels of suicide. In England and Wales, suicide and homicide prison deaths have also gradually declined. Between 2004 and 2005, for example, suicide deaths fell by 14%. In Australia, prison deaths have generally declined or remained stable, with one notable exception. Between 1980 and 1997, Australian prisons experienced an increase in suicide, which by 1997 came to account for 42% of all prison deaths. Efforts since that time have served to reverse this trend.

In Russia, which has the second largest prison population only to the United States, a dramatic increase in prison deaths caused by drug addiction took place during the 1990s. Between 1996 and 2003, the general Russia population experienced a ninefold increase in prison addiction deaths, and the prison system was no exception. However, recent changes in Russian law, with more emphasis placed on treatment rather than incarceration, should ease the rise of prison deaths due to drugs.

In Latin America, a basic problem that contributes to prison deaths is the widespread policy of incarcerating untried persons for long periods of time. In Argentina, for example, fully 50% of the 60,000 prison inmates have not been tried, but are confined to police lockups. The same situation exists in Columbia. In fact, lengthy incarceration of untried persons in Latin America is a general pattern and reflects the economic and political situation in those areas.

On the other hand, India has one of the lowest crime rates in the world. The major issue of prison deaths in that country is dehydration due to excessive heat. Prison deaths and crime are low in that nation.

Diseases and Related Matters

For many nations, an increase in prison deaths has been due to infectious diseases, especially AIDS. Many of the affected nations are also lacking in transparency in reporting such deaths. Despite these difficulties, there are sufficient data available to reveal the increase in prison deaths from infectious diseases, and in some cases the increases are large and the level of mortality high.

Sub-Saharan Africa has long been considered the epicenter of the AIDS epidemic. Prison populations in those areas tend to reflect the trends of the general population. South Africa is one of the few developing nations to provide fairly extensive statistical data about prison deaths in general and disease-related deaths in particular.

Since 1996, the number of prison deaths in South Africa increased by 584%, of which 90% to 95% were AIDS-related. It is estimated that about 42% of the prison inmates in South Africa are HIV-positive. Environmental conditions in South African prisons make the problem much worse. Overcrowding is rampant, and several prisons do not have running water. A judicial review recently pointed out that most prisons in that country do not abide by the South African law that requires testing of all new inmates for infectious diseases. As a consequence, life expectancy is lower and mortality

rates much higher for prison inmates in South Africa than is the case in the general population.

HIV/AIDS is increasing in other African prison systems as well. In Namibia, for example, the number of prison deaths due to AIDS has been on the rise in recent years, and about 60% of all prison deaths are AIDS-related. In Kenya, officials report that HIV/AIDS causes some 10 to 15 prison staff deaths monthly.

In Russia, although HIV/AIDS is also a problem, a much larger and more dangerous trend in prison deaths has been the spread of tuberculosis, including multidrug-resistant strains that were first detected in 1991 and have since spread rapidly inside the Russian prison system and far beyond. The rate of tuberculosis infection inside the Russian prisons is 17 times higher than that of the general population, and the number of prison deaths is 8 times higher than that of the general population. By 1999, these rates had increased to 58 times and 28 times, respectively. Indeed, it can be said that the Russian prison system has become the epicenter of a tuberculosis epidemic that has spread far beyond its prisons. Between 1990 and 2006, the tuberculosis rate in Russia had tripled (to 1 person per 1,000) and was 15 times higher than that in the United States. About 10% of Russian inmates have active tuberculosis.

Even more alarming has been the rapid increase of multidrug-resistant tuberculosis strains, which now constitute approximately 30% of all active tuberculosis cases in that country. In addition, HIV-positive inmates are far more likely to carry the multidrug-resistant strains, which serves to elevate prison deaths even more. The annual release of tens of thousands of prison inmates has made the Russian prison system the main source of rapidly spreading multidrug-resistant strains of tuberculosis.

It is reported that within the Indonesian prison system, some 72% of all prison deaths are due to infectious diseases. A lack of funds and overcrowded prisons make the situation even worse.

In contrast, in the United States AIDS deaths in prisons are decreasing. In 1995, a peak of 1,010 inmates died from AIDS in the United States; by 1999, this number had decreased to 242 inmates. But while AIDS-related deaths are down in U.S. prisons, HIV infection rates are on the increase. Although the rate of HIV infection increased only 6% for the general population between 1995 and 1999, the corresponding rate for prison inmates was 19%.

Political Oppression

The most secretive type of prison deaths are consequences of political activities by the state, either through direct action or through neglect. But it is virtually impossible to gain insights based on an accurate count of such prison deaths; most of the evidence is indirect and often contradictory. In all too many cases, some governments go to great lengths to hide such prison deaths in order to minimize public criticism.

Latin American and Caribbean prisons house over half a million inmates, usually under unsanitary and overcrowded conditions and with staffs that are rarely trained and generally corrupt. As a result, riots, gang wars, and staff assaults create many prison deaths in such countries, but few are openly reported. In Brazil, for example, Carandiru Prison experienced a riot in 1992 in which 111 inmates were killed. On May 29, 1998, another 22 inmates were killed in a gang war inside the São José Prison. Scores of inmates die annually from inmate-on-inmate abuse. One unintended consequence of widespread violence in Brazil's prisons has been to produce more highly organized and more formidable gangs. In Brazil, prison gangs have become the main opposition party to prison abuse.

China's prison system has been used by the state to systematically eliminate its enemies, real or imagined. In recent years the main focus of Chinese wrath has been directed against the Fulan Gong (also known as the Fulan Dafa). In 2004 alone, more than 140 Fulan Gong members died in custody. Between 1999 and 2001, government officials inside China confirmed the deaths in custody of well over 1,600 members of Fulan Gong. As hundreds of thousands have been detained by the state, the prison death toll is almost certainly much higher than officially stated.

Tibetans, including many monks, have also been the victims of death while in Chinese custody. Again, the figures are difficult to obtain, but some information is reported. It was officially reported that on June 7, 1988, five Tibetan nuns died while in custody.

Similar levels of prison deaths due to oppression have been noted in other countries. In Uzbekistan, for example, state violence inside prisons is directed at Muslims who attempt to practice their religion outside state controls. In Georgia, the state confirmed 24 deaths in custody in the year 2006 alone. In Turkey, inmates are routinely killed by military units sent to quell a disturbance of one kind or another. Kenya routinely tortures inmates to death.

In sum, for countries that are fairly wealthy and even those with some form of democracy, the unmistakable trend in prison deaths has been downward. One exception to this trend is an increase in prison deaths due to aging. For many countries, the unmistakable trend in prison deaths due to infectious disease has been up and, in some cases, dramatically so. For many other countries, because reliable data are so difficult to acquire, the trend in prison deaths due to various types of oppression has been unknown. More transparency in these nations will serve to drive these types of prison deaths down.

Ronald E. Jones

See also Causes of Death, Contemporary; Causes of Death, Historical Perspectives; Mortality Rates, Global; Mortality Rates, U.S.; Suicide

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Prolonged Grief Disorder

Because loss is endemic to human life, so too is grief, defined as the psychological response to the loss of another in all of its emotional, cognitive, and behavioral aspects. Fortunately, as research shows, most people ultimately adapt well to bereavement, typically regaining their psychological equilibrium and moving on with life after some weeks or months of acute mourning, although they frequently will continue to miss their loved one for a considerably longer period of time. However, many studies also identify a subset of 10% to 15% of the bereaved for whom grief is both intense and chronic, persisting at disruptive levels for many months or years. This condition, termed *complicated grief* or (more recently) *prolonged grief disorder,* is one whose coherence, correlates, and consequences have received increasing scrutiny over the past decade in both psychiatric and psychological literatures.

As articulated most clearly by Prigerson and her collaborators, the diagnosis of this form of debilitating and intractable grieving is both more clinically precise than the vague and sometimes unsubstantiated depictions of "pathological" grief that have long populated professional discourse and better anchored in progressive programs of research. As it is presently being proposed as an officially recognized psychiatric disorder, the diagnosis applies to patterns of bereavement adaptation marked by persistent inability to function in work, family, or social roles over a period of at least 6 months, in the presence of chronic and intense yearning or longing for the deceased, and several associated symptoms of inability to accept the death, trouble trusting others, disruptive bitterness and anger, uneasiness about "moving on" with life, numbness and detachment, agitation, and a corrosive sense of meaninglessness regarding one's life in the present or future. It is thus conceptualized as a form of pervasive and profound separation distress following a sundered attachment, one that deprives the survivor of a secure base for

exploring the world as well as a safe haven from its storms and challenges, while also increasing the risk of severe and even life-threatening psychological and medical disorders.

Predictors of Prolonged Grief Disorder

Several factors predispose people to prolonged grief disorder following major loss. These include such childhood experiences as a history of early parental death or divorce. Likewise, later experiences in adulthood can also increase the risk of chronic and profound grief, including loss of a first-degree relative, such as a parent, partner, sibling, or child; sudden, unanticipated, or violent death of a loved one; and high levels of dependency on the other for a sense of personal well-being. Several of these factors suggest the role of attachment insecurity in increasing a person's vulnerability to complicated bereavement, as earlier experiences leave some people with anxieties about abandonment by others or a sense of insufficiency in meeting life's challenges on their own. In such cases, later losses of a loved one through death can trigger these vulnerabilities, provoking intense and extended separation anxiety that interferes with their post-loss adaptation.

Outcomes of Chronic Grief

In addition to the significant psychological suffering required for diagnosis, symptoms of prolonged grief disorder, when present to a marked degree 6 to 12 months or longer after the death, are associated with a broad range of functional impairments, such as poor work performance or trouble meeting family responsibilities as well as overall reductions in quality of life. Perhaps of greater concern, they are also associated with several specific health risks, including sleep disruption, substance abuse, compromised immune function, hypertension, heart failure, cancer, and suicide. It therefore is not surprising that bereaved persons who struggle with prolonged grief report higher utilization of medical services and more frequent hospitalization than people with similar losses whose grief is less profound and extended, and that these effects have been observed for as long as 4 to 9 years after the death. The fact that these negative outcomes emerge even when levels of depression and anxiety are taken into account argue for the uniqueness of a prolonged grief diagnosis and caution against considering bereavement complications simply as a relabeling of conventional psychiatric conditions.

Distinctiveness of Prolonged Grief Disorder

Evidence indicates that bereaved people can respond to their loss in a variety of ways that range from resilience or even personal growth, on the one extreme, to life-limiting or life-threatening adaptations on the other. In the latter category, loss can trigger major depression in perhaps 10% of those who suffer it, and post-traumatic stress disorder (PTSD) in still others. However, these conditions are importantly different in some respects from prolonged grief disorder as defined here. For example, whereas depression is characterized by a predominant emotional state of sadness and anhedonia (the inability to experience pleasure) and PTSD is associated with predominant emotions of fear and panic, prolonged grief is defined by profound separation distress and acute loneliness. Furthermore, cognitive themes in depression and PTSD focus on a sense of the self as unlovable or a failure, in the first instance, or as weak and vulnerable in the second. In contrast, in prolonged grief the bereaved person's central preoccupation is with the self as alone in the world, even in the presence of caring others. Brain imaging studies also distinguish between depression and acute grief, with the former suppressing activity in those brain centers responsible for processing personal memories, whereas the latter actually produces heightened activation of these same structures. This corresponds to reports of impaired concentration and recall among depressed people, in contrast to the experience of intensely grieving people, who are often drawn to obsessive review of memories of their loved one to an extent that it is difficult to orient to a changed future. It is therefore important to recognize that any given bereaved individual can struggle with depression, posttraumatic stress, prolonged grief, or any combination of these conditions, but also to bear in mind that they should not be considered equivalent in their phenomenology (how they are experienced) or neurophysiology. Evidence strongly indicates, however, that a diagnosis of prolonged grief disorder at 6 to 12 months

post-loss predicts the subsequent development of major depressive disorder, PTSD, and generalized anxiety disorder in the year that follows.

Prolonged Grief and the Crisis of Meaning

Although much of the research on prolonged grief has concentrated on establishing diagnostic criteria for the disorder and developing scales for validly and reliably assessing its symptoms, investigators have also begun to study processes that could explain some of its core features. One such process is the struggle of many bereaved people to reaffirm or reconstruct a world of meaning that has been shaken by the loss, particularly when the death assaults the survivor's "assumptive world" that life is predictable and that the universe is benign. Meaning, in this sense, can have many components, including understanding the conditions that led to the loved one's death, finding philosophical or spiritual significance in the loss, deriving unsought benefit from the experience (such as revising life priorities or drawing closer to others), and developing greater maturity or strength in the course of survivorship. Across a variety of different losses—of parents, grandparents, children, siblings, and friends—research indicates that the failure to find meaning following the loss, especially in terms of "making sense" of the death itself, is associated with higher levels of complicated grief symptoms. For example, it appears that an intense and protracted search for meaning is especially likely to accompany losses that are sudden and premature, as in the death of a young person, and that a ruminative preoccupation with the loss is an indicator of long-term depression, anxiety, hostility, and grief. Moreover, a failure to find spiritual or secular meaning in the loss accounts for nearly all of the heightened symptoms of complicated grief following suicide, homicide, and fatal accidents as opposed to natural anticipated deaths (as from progressive cancer) and even natural sudden deaths (as from heart attack). It therefore could be argued that prolonged grief disorder is, among other things, a crisis in meaning induced by the loss of an important attachment figure, driving efforts to find significance not only in the loss but also in one's changed life as a survivor. Some bereavement scholars have conceptualized this in terms of attempting to heal ruptures in the client's life story introduced by the loss, through integrating it into the survivor's "self-narrative" rather than simply attempting to have the client "recover" from it.

Treatment of Prolonged Grief Disorder

Research has called into question the effectiveness of grief therapy for bereaved children and adults, perhaps in part because treatment is often offered to otherwise resilient mourners who would do well without intervention. In contrast, it is clear that those persons who display substantial symptomatology are more likely to benefit from treatment, especially when they meet criteria for complicated or prolonged grief. For example, recent research indicates that a specially designed complicated grief therapy outperformed a more general psychotherapy for carefully diagnosed bereaved people and was especially helpful for those whose losses were traumatic. A second study found that a series of thoughtfully tailored writing assignments delivered over the Internet that helped people express and explore their stories of loss substantially reduced symptoms of complicated grief relative to a no-treatment comparison group. On the other hand, it appears that antidepressant medication does little to address the core symptoms of bereavement complication, even when it usefully reduces symptoms of depression. Studies like these reinforce the conclusion that prolonged or complicated grief is a unique disorder that calls for distinctive approaches to diagnosis, assessment, and treatment.

Future Directions

Although much more is understood about prolonged grief than was the case 15 to 20 years ago, much remains to be learned. For example, little is known about the prevalence of this disorder or even its potentially unique symptomatic expressions in children as opposed to adults, or what short- and long-term consequences might follow it during childhood and adolescence. Additionally, because research on bereavement complications has centered on individuals, little is known about the family and social dynamics associated with prolonged and profound grief. Even though some

studies suggest a link between this condition and a lack of social support, it is unclear at this point whether bereaved persons who lack sufficient support are more prone to prolonged and complicated grief reactions, whether such mourners tend to exhaust or repel potentially supportive figures with their unremitting anguish, or whether both dynamics hold, so that an initially thin support network is stretched beyond its limits by the high demands of caring for someone apparently unresponsive to helpful overtures.

Despite solid scientific evidence for the legitimacy of a prolonged grief diagnosis, controversy persists about its inclusion in standard manuals of psychiatric disorders. Although some research indicates that the bereaved themselves would welcome such a diagnosis if they themselves suffered from disabling grief, some professionals are concerned that its official acceptance would contribute to "medicalizing" grieving, rather than treating it as a normal psychosocial transition, an existential challenge, or spiritual quest. Because response to bereavement is the province of diverse groups that range from hospice volunteers to professionals in such disciplines as nursing, social work, pastoral care, psychology, and psychiatry, debate concerning the inclusion of prolonged or complicated grief in medical handbooks can be expected to continue for some time to come. Even at present, however, it is clear that clinical research has expanded our understanding of the distinctive symptoms, risk factors, psychological processes, and outcomes of profound and prolonged grief, and has begun to contribute to more relevant interventions for those who suffer from this life-limiting condition.

Robert A. Neimeyer

See also Ambiguous Loss and Unresolved Grief; Chronic Sorrow; Disenfranchised Grief; Grief, Types of; Grief and Bereavement Counseling; Homicide; Sudden Death; Suicide Survivors; Widows and Widowers

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PSYCHACHE

Psychache, a concept created by Edwin S. Shneidman and fully developed in the 1990s, refers to unbearable psychological pain most often found in suicidal individuals. The term comprehends the hurt, anguish, or ache that takes hold in the mind; the pain of excessively felt shame, guilt, fear, anxiety, loneliness, angst, dread of growing old or of dying badly. Although Shneidman admits that each suicide is a multifaceted event, that biological, cultural, sociological, interpersonal, intrapsychic, logical, philosophical, conscious, and unconscious elements are always present, he suggests that the essential nature of suicide is psychological, meaning that each suicidal drama occurs in the mind of a unique individual. Advocates of the concept focus on the mental aspects of suicide

and suggest that the study of suicidal acts should concentrate on the phenomenology of suicide.

Psychache can be clearly distinguished from depression or other psychiatric disorders for the uniqueness of suffering perceived by the subject and for the fact that he or she cannot stand it; the individual cannot see a way out and believes that ending life is a solution. Shneidman suggested investigating psychological pain referred to as introspective experience of negative emotions through the Psychological Pain Assessment Scale. This instrument rates present and worst-ever psychache and, from the standpoint of the researcher, should help clinicians and researchers explicate the concept of psychache, explore its theoretical dimensions, and begin the process of developing operational meaning between psychache and suicidal behavior.

Shneidman's great efforts to understand negative emotions in individuals and how to bridge the gap in communication of human suffering was one of the major sources of inspiration of such a concept. The pioneering challenge to introduce the psychological element in the study of suicide began in 1949 when Shneidman serendipitously found himself comparing, in blind conditions, genuine and simulated suicide notes and then trying to distinguish between the two types. In attempting to understand the mind of the suicidal individual, a major contribution was made when the first psychological autopsies were performed. These were retrospective investigations of the deceased person, within several months of death, using psychological information gathered from personal documents; police, medical, and coroner records; and interviews with family members, friends, coworkers, school associates, and health care providers to classify equivocal deaths or establish diagnoses that were likely present at the time of suicide. Taking advantage of this background and after decades of research in the suicidal mind, it was concluded that the main ingredient of suicide is the unbearable psychological pain and that suicide may be, *at least in part,* an attempt to escape from this suffering. Conceptualization of psychological pain as an ingredient of suicide is traceable in works published in the 1980s by Shneidman, such as in the classic Aphorisms of Suicide Assessment, and has some implications for psychotherapy wherein the role of psychological pain is mentioned as related to the fact that if tormented individuals could somehow stop consciousness and still live, they would opt for that solution. Shneidman believes that in suicide, *death* is not the key word. The key words are *psychological pain*, and if the pain were relieved then the individual would be willing to continue living.

In such a view, suicide is functional because it abolishes the pain for the individual. Suicide occurs when the psychache is deemed by that individual to be unbearable. It is an escape from intolerable suffering; and this construct views suicide not as a movement toward death but a remedy to escape from intolerable emotion and unendurable or unacceptable anguish.

Psychache is associated constriction or narrowing the range of options usually available to an individual. Suicidal individuals experience what may be defined as dichotomous thinking, that is, wishing either some specific (almost magical) total solution for their psychache, or cessation—in other words, suicide. A dialogue takes place in the mind where options to solve the pain are scanned. Suicide, although considered in the first steps of this process, occurs after a given length of time when efforts to find amelioration of psychache have failed.

Shneidman's view of psychache lies in the fact that the main sources of psychological pain, such as shame, guilt, rage, loneliness, and hopelessness, emerge from frustrated or thwarted psychological needs. Shneidman's conceptualization of psychological pain is deeply rooted in the psychological needs reported in Henry Murray's *Explorations in Personality*. These psychological needs include the need for achievement, affiliation, autonomy, counteraction, exhibition, nurturance, order, and understanding. It would appear that the frustration of some psychological needs cannot be tolerated, and these are needs that the person would die for. These vital needs come into play when the individual is under threat or duress. Suicide occurs in the dark moment when life has unhappy aspects, such as sorrow, shame, humiliation, fear, dread, defeat, or anxiety.

According to classical suicidology, suicide occurs when perturbation and lethality exist in the same individual. Perturbation refers to how upset, disturbed, agitated, or discomposed the individual is; lethality (also referred to as suicidality) refers to the likelihood of an individual's being dead by his or her own hand in the future. It is important to first deal with perturbation (psychache) because it

energizes lethality. In order to perform such task, clinicians should inquire about the client's psychological pain. The classical Shneidmanian suggestion is to ask key questions of the suicidal person: "What is going on?" "Where do you hurt?" and "How may I help you?" Although simple, these basic questions provide some access to inner feelings of the perturbated person.

Treatment for psychache should be performed through anodyne psychotherapy, which aims at the mollification of unbearable psychological pain. The most important key in anodyne therapy is a tailor-made focus in the alleviation of that patient's frustrated psychological needs considered by the person to be vital to continued life. Therapy of psychache involves the fact to be empathic and resonate to the patient's private psychological pain. Therapists should be aware of the uniqueness of patient's suffering and should try any possible solutions to change the patient's psychological pain from unbearable and intolerable to barely bearable and somewhat tolerable.

Maurizio Pompili

See also Good Death; Suicide; Suicide, Counseling and Prevention; Suicide, Cross-Cultural Perspectives; Thanatology

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Psychological Autopsy

The term *psychological autopsy* refers to the reconstruction of a deceased biographical and psychological state preceding death when suicide is suspected. The procedure is used in clinical settings and within the scientific field, as well as in the development of suicide prevention and therapy programs. A psychological autopsy is conducted when the circumstances of death are uncertain. In this case investigators collect oral and written information from the environment of the deceased, such as in interviews with survivors (e.g., family, friends, and medical personnel) and documents (e.g., letters, diaries, police reports, and coroner's records). The main questions a psychological autopsy should reveal answers to are (a) How did the person die? (b) Why did the person (possibly) commit suicide? and (c) What was the exact nature of death?

In the late 1950s the term *psychological autopsy* appeared for the first time in the work of suicidologist Edwin Shneidman and his colleagues at the Los Angeles Suicide Prevention Center and the Los Angeles Medical Examiner's Office. After the investigation of a great number of unsolved death cases, Shneidman and his coresearchers developed this procedure to rebuild a person's history and to reveal the victim's motivation to commit suicide. In the first place, the psychological autopsy focuses on the last days before death, although Shneidman emphasizes that the investigation must range further than that. Survivors are asked about the personality, lifestyle, and relationships of the deceased. A brief outline of the personal history must also be provided, and questions regarding psychological stress can go back to about a year before death.

The traditional use of a psychological autopsy had been in coroners' reports in addition to the regular physical autopsy, because rather than focusing on the cause of death it focuses on its context. Furthermore, the procedure had been used in research for defining risk factors of suicide in adults. Later the research had been expanded to the investigation of suicidal children and adolescents. From the 1970s the focus shifted increasingly toward examination of risk factors, and the psychological autopsy became an important instrument for the treatment of potential suicides and failed suicide attempts. Another function had been recognized in the interviews with survivors. If the investigator is working with much accuracy and empathy, the interviews can have a therapeutic value for the bereaved. By talking about and confronting their feelings and thoughts, the survivors

are able to deal with this difficult experience. The psychological autopsy can thus be used for pre- and postvention of suicidal acts.

In the investigation of suicide, data can be divided into two sets: prospective and retrospective. The retrospective data are collected during a psychological autopsy, whereas prospective data refer to clues before death (e.g., the person talking about suicide, previous suicide attempts, feelings of depression and hopelessness). This division is important in the study of suicide because there are different clues, which therapists and doctors should be aware of. Psychological autopsies reveal that when suicide is certain as the mode of death (e.g., when a goodbye letter or a weapon in the hand of the victim is found), prospective clues can be found in almost all cases. Suicidal people are aware of the fact that they want to die, and they also think of how they will be remembered after death. Shneidman refers to the imagination of how a person wants to be remembered as the "postself." The psychological autopsy is in fact a way of measuring the postself by collecting information from the environment of the deceased. The suicide note is the most direct measure of the postself in the case of suicide. The person leaves his or her last words to the world, words that will be remembered. In other personal documents, such as diaries or notes, the postself becomes visible when the victim fantasizes how the world would be without him or her. In the analysis of retrospective data in a psychological autopsy, the postself is represented in the memory of the survivors.

To conclude, there is not a standard way of conducting a psychological autopsy. Researchers use different methods: semistructured interviews, standardized questionnaires, and written data. The multidisciplinary character and the specific study of every case separately can reveal more background information about the exact mode of death. Additionally, in the scientific field, researchers strive for standardization of the procedure so as to compare different cases more accurately. The methodological difficulties lie mainly in the diverse informants who provide different information about the deceased. Nevertheless, the psychological autopsy is a significant instrument in the investigation of death because it reaches further than the classic taxonomy of death modes (natural, accidental, suicidal, and homicidal death). Today's researchers try to combine the "classic" psychological autopsy with other methods, such as the narrative approach, by, for example, the use of life charts. The use and methods of the psychological autopsy are still under development.

Joanna Wojtkowiak

See also Postself; Suicide; Suicide, Counseling and Prevention; Suicide Survivors

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Putrefaction Research

Putrefaction research is the study of decaying matter upon an organism's death. Although this area of inquiry extends to both the plant and animal worlds, the latter is the focus of this entry. When an animal dies, including human beings, there is a series of stages in which the body breaks down, or decomposes, into simpler states of matter. Within 5 minutes of death, the human body begins to decompose and will continue to do so in stages until it is reduced to mere skeletonized bone. This initial stage of decomposition can take anywhere from a few days to years, depending upon where and how the corpse is preserved and under what environmental conditions, as both factors greatly influence the rate of decay. The first stage of animal decomposition, called autolysis, or self-digestion, begins nearly immediately following the lack of oxygen in

the body. Without sufficient oxygen, cells are unable to excrete and process carbon dioxide, which results in an elevated pH level in the blood. This, in turn, poisons the body's cells and causes them to rupture, releasing cellular nutrients. Autolysis, which is an internal process whereby the body's chemicals control tissue decomposition, eventually affects every cell, typically within a few days after death has occurred. As more and more tissue and organs break down, the body begins to become fluid-like and is marked by blisters and skin slippage.

Cellular breakage continues until no oxygen remains in the body, signaling the beginning of putrefaction, a process during which microorganisms, including bacteria, fungi, and protozoa, break down the remaining soft tissues. These microorganisms ensure that the body's tissues become volatile organic compounds (VOCs), which are gases (e.g., hydrogen sulfate, carbon dioxide, methane, and ammonia) and liquids that physically alter the corpse. These VOCs attract a plethora of insects, most notably *Sarcophagidae* (flesh flies) and *Calliphoridae* (blow flies) in the early stage of decomposition, which then lay eggs on the body and feed off of the flesh.

During the putrefaction process, the body undergoes physical changes. Blood begins to pool after death and hemoglobin is broken down into sulfa hemoglobin, resulting in the corpse's now greenish hue (liver mortis). This hemolyzation process, aided by bacteria, also results in the formation of red marks along the body's veins. In time, the red markings will then turn a shade of green, a process in putrefaction called marbleization. As microorganisms continue to decompose tissues, more gases are released from the cells, especially those in the abdomen and face, and the body becomes visibly bloated and marked by a strong odor. The stomach and intestines become so laden with gases that their contents eventually submit to the pressure and are expelled from the anus. There is an increase in insect activity as compared to during the autolysis stage, although it is characteristically the same *Calliphoridae* family of insects. It is especially common in warm environments for the body to undergo saponification, the development of a pale yellow waxy or slick substance, called adipocere formation, when the body's fat deposits turn into soap due to elevated pH levels caused by bacterial activity.

As putrefaction continues into what is called the black putrefaction stage, the corpse turns from green to black as a result of the body cavity rupturing under the intense gaseous pressure. It is at this point that the bones become visible and insects and other wildlife, including scavengers, descend upon the body and expedite further decomposition. Black putrefaction ends when the body dries and the remaining tissues dehydrate and fuse to the skeleton. This drying, referred to as desiccation, is largely dependent on the climate; bodies left in warm, dry climates reach mummification more readily than those in moist areas. As the body dries out, it loses the odor that marks putrefaction because little tissue remains after scavengers have removed all organs or the organs are decomposed by way of autolysis. Once the body is without any soft tissue, it is then referred to as a skeleton. Dry decay, or the deterioration of the skeletal remains, is commonly a very long process that takes anywhere from a few years to centuries depending upon the environmental conditions and burial practices. In order for bones to decompose, the protein and minerals must separate. Bone protein and its rate of leaching away from minerals are affected by the soil type, its pH level, and the presence or absence of groundwater; as such, the bone corrosion phase is widely variable.

Research Process

Putrefaction researchers are concerned with the rate of decomposition and how myriad variables influence this process. The study of decomposition and putrefaction is called taphonomy, and these researchers are interested in the complex relationships between the environment and the decaying corpse. Often, their job is to determine time of death, an estimate that has important implications for crime scene investigations. For instance, there is a basic formula that measures putrefaction for a person lying in the ground; this formula factors in the temperature ($y = 1285 / x$, with y equaling the number of days since death and x equaling the temperature in centigrade). Typically, the warmer the temperature is, the faster the decomposition rate is, although soil conditions, cause of death, prior embalming, type of clothing, depth of burial, and presence of scavengers also drastically alter this process.

Researchers who specialize in the insect activity on and within dead bodies are called forensic entomologists. They are interested in documenting the species and number of bacteria, fungi, and insects that are present during the various stages of decomposition. When a dead body is found, criminal investigators can gain tremendous insight from the forensic entomologists' work because the presence and absence of necrophilous insects and bugs (animals that are attracted to putrid bodies) and their stage of development can help determine the time that elapsed since death occurred. But insect activity varies from place to place due to temperature and other factors, so investigators can potentially learn whether or not a person died in a given locale or if their body was moved postmortem.

The Body Farm

A body farm is a research center where scientists study the human decomposition process. These facilities provide an environment whereby death and decay can be scientifically examined by replicating various settings. Body farms are an important component to better understanding the human decay process and how particular environments may affect the deceased's body. For example, scientists may reenact a murder victim left in a body of water for days prior to discovery or a victim burned posthumously. By studying the process by which bodies decompose when left to the elements, it is possible to accurately determine the postmortem interval in real time and recover any evidence of foul play. Thus, the data collected at body farms provide crime scene investigation teams and forensic anthropologists with important information regarding decomposition and proper techniques for collecting evidence from a victim's remains and the surrounding crime scene area. Because bringing a perpetrator to justice often requires that investigators place the criminal at the scene, the body farm staff are primarily interested in accurately determining the time of death based upon the state of the body upon discovery.

Caitlin E. Slodden

See also Body Farms; Decomposition; Forensic Anthropology; Forensic Science

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Quality of Life

Much of the human experience has striven for happiness and the satisfactions of life. Well-being and satisfaction with family, job, leisure, and other domains of life characterize the quality of life (QOL). QOL developments such as measurement and research findings will be explored to show the rise of this interdisciplinary topic. Satisfaction comes from many sources, one being the idea of survival.

Survival of the species constitutes a domain of the QOL, according to R. Mukherjee, who canvassed the writings of W. I. Thomas, R. S. Lind, L. L. Thurstone, A. H. Maslow, and others in order to identify our cardinal valuations. A cardinal value of humankind is survival. Seeing one's heritage, genes, and traditions passed on to the succeeding generations before death provides gratification and fulfillment. Suicide ends the life of some, but the greatest threats to life are man-made and natural disasters. During the 20th century, 250 formally declared wars led to the demise of more than 100 million people. Genocide, pogrom, religious conflicts, and political hostility took at least 145 million lives during the 20th century. These losses affected the QOL of at least an additional 500 million. Man-made disasters have claimed the lives of thousands in the form of automobile, ship, aircraft and train accidents, explosions, mine disasters, nuclear accidents, and fires over the past 10 years. Man's adaptation to the fruits of the Industrial Revolution has come at a cost to survival.

Natural disasters also led to loss of life, crushing the QOL of thousands. In the 10 years ending 2006, earthquakes caused more than 339,000 deaths worldwide. During the same period, floods and tidal waves took more than 273,000 lives, affecting the QOL of many thousands of family members left behind. Other natural disasters have brought death to tens of thousands, including storms, hurricanes, typhoons, blizzards, and volcanic eruptions. We have not yet learned to avoid nature's fury.

Evolution of Quality-of-Life Measures

In the 1960s, the gross domestic product (GDP) was looked upon as a general but unsatisfactory index of the well-being of society. Social indicators were expected to provide more sensitive indices. They have done so. In the 1970s, scholars worldwide began to contrive better indices of well-being. Marketing scholars saw QOL measures as reflections of success in distributing goods and services to satisfy needs. Psychologists developed measures of subjective well-being. Economists and sociologists employed ecological measures of aspects of QOL to reflect the status of regions or social systems. Scholars worldwide began to survey populations and identify population categories that evidenced better or worse QOL. However, only Bhutan, in Asia, with a population slightly over 1 million, has substituted QOL measures for the economic GDP.

Conceptualization and Application of QOL Measures

Three approaches to measurement have evolved. Sensitive to health conditions, scientists studying effects of medical interventions have developed extensive protocols for QOL of people with specific health conditions or therapy needs. Psychologists, concerned with mental health and other mental conditions, have focused upon subjective well-being, measured by questionnaire items that allow the respondent to express happiness and life satisfaction. Finally, economists, sociologists, geographers, and others rely upon both survey findings and reported data combined to compare the QOL of cities, regions, and nation-states. These efforts have resulted in an understanding of segments of the population that are better or worse off and that should receive various services to improve their well-being.

Improving well-being requires knowing the areas of life that, if properly treated, would result in a better QOL. To this end, researchers have disaggregated the measure of QOL into domains. An early study conducted in the 1970s isolated five major "life concerns": job, community/neighborhood, civic/government, leisure/sociability, and fun/personal accomplishments. Others have refined this approach through factor analysis of item responses on extensive surveys. Robert Cummins reviewed 152 studies to identify their common domains, finding that 68% of domains could be compressed into seven categories: material well-being, health, productivity, intimacy, safety, place in community, and emotional well-being. These are just two examples; other definitive sets of domains have been developed during the 1990s. Abbott L. Ferriss assigned these domains to the following categories: survival of the species, social acceptance, mastery, affective autonomy, intellectual autonomy, egalitarian commitment, harmony, conservatism, hierarchy, and health. The utility of such domains lies in their relation to improving the QOL. For example, welfare would be improved through increasing the production of wealth through investment. The hierarchy and mastery domains would be improved through investment that would provide education and employment opportunities.

The Quest for Global QOL Measures

Scholars have devoted much effort to refining measures of QOL so that now reliable cross-national and international studies are possible. Health-related QOL measures are devised to reflect progress of treatment of particular health conditions. An example is the Canadian Occupational Performance Measure. It has the client identify activities of importance and rates the performance for personal care, functional mobility, community management, work, household management, and play/school. The interviewer rates the client on each of these, and the sum of the ratings provides an overall assessment. The result is used to detect progress or retrogression over time, or the effect of particular therapies. Other health-related QOL measures are for specific health conditions.

The most commonly employed measures are developed from questionnaire responses to questions reflecting the subjective well-being of the respondent. Robert Cummins developed a QOL scale that is being administered in a number of nations that will provide international comparison, while Ed Diener produced a QOL measure appropriate for detecting trends in the United States. In turn, interest in the socioeconomic progress of nations led to the development of indices of reflecting change even in less developed areas, such as Africa and Asia. European nations have also been surveyed for QOL and mental health in an extensive 10-nation study.

The United Nations Development Program has contrived a Human Development Index consisting of the measures of buying power per person, literacy and school attendance, and life expectancy at birth. These objective measures combined provide international comparisons. These are examples of the many measures that are being developed; some are designed for special populations, interests, and age groups.

In addition to subjective measures, objective measures are employed to establish the physical basis for QOL. The UN Development Index is one example. These indices include such measures as per capita income, suicide rates, length of life, environmental toxin indices, measures of housing conditions, and other such objective features that comprise the necessities of living. They usually reflect the QOL of residents of an ecological area, such as a

county or a state. Combining 12 objective measures and subjecting them to a factor analysis led to identification of four major components of the QOL: security, mastery, harmony, and autonomy. The study demonstrated the influence of the production of wealth on the QOL. A stress index by state was strongly inversely associated with the percent of the state's population involved with religion.

Worldwide, scholars have analyzed QOL surveys, both objective and subjective, and have come to some interesting conclusions. The relationship between QOL measures and per capita income follows a curve that shows an increase in QOL as income increases up to a point. Beyond that point, an increase in income prompts little increase in QOL. The point in the curve appears to represent adequate income for life's necessities, beyond which income prompts only small increases in QOL.

This relationship is further explored by U.S. data from the General Social Survey that carries happiness and family income items. It shows families with high incomes to be 57.3% happy and 5.3% with high income "not so happy." At the other extreme, low-income families are 30.9% happy, while only 6.5% are "not so happy." These figures add to 100% of the GSS sample of families. Obviously money has some impact on happiness, but it is not the only influence. Perhaps the Roman, Cicero, found the key to happiness: "…a happy life consists of tranquility of mind." Tranquility of mind and other positive happy modes are lodged, recent research shows, in the left prefrontal cortex of the brain, perhaps indicating that happiness can be nurtured through mental training. But populations of countries vary in happiness. Switzerland, Sweden, the United States, and Argentina rank high, whereas Zimbabwe, Russia, and India rank low, according to the World Database of Happiness.

Studies show that participation in religious activities is associated with happiness. It may be that happy people gravitate to religious services, but it is more likely that religious values and the association with other like-minded members contribute to happiness. Doctrinal differences of religious bodies evidently have an effect; evangelical and fundamentalist religious adherents report themselves happier than other mainline and liberal bodies. People with no religious affiliation rank lowest in happiness.

While the notions of welfare and happiness have enjoyed academic interest, the general concept of QOL is relativity new. Its future in policy and program development, research, and general usage promises to expand. This will depend on several developments. With governmental interest in improving the general welfare, QOL measures could be the criterion. QOL surveys identify population segments in need of attention. With attention through publicly supported programs, QOL assessments of progress will be needed. The current suggestion of a periodic national survey of QOL of the country, following the lead of some European countries, will become a reality. QOL measures should then augment or supplant GDP as a measure of the general welfare of the population.

The Social Quality Concept

Social theory should be enhanced though employing QOL as a criterion for social studies, as personality dimensions and mental health measures have sometimes been used in the past. Research will improve our understanding of well-being and will be an important ingredient of QOL theory.

There is a rising interest in the ingredients of the good life. European scientists have advanced the concept of social quality, seeking to conceptualize it in terms of a fourfold matrix including socioeconomic security, social inclusion, social cohesion, and social empowerment. Thus, the concept of QOL is expanded from an individual condition of well-being to a social environment of social forces conducive of the good life. A theory of social quality with special reference to health has been developed.

Abbott L. Ferriss

See also Acute and Chronic Diseases; Disasters, Man-Made; Disasters, Natural; Good Death; Life Support Systems and Life-Extending Technologies

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Race and Death

The concept of race is used to differentiate among groups based on criteria such as physical characteristics (e.g., skin color and hair texture) and sociocultural heritage. Ethnicity is a concept that focuses primarily on sociocultural heritage. In the study of health status, including death rates, race tends to be emphasized in order to compare differences between racial/ethnic minorities and the white majority group in society. Although there have been significant declines in overall death rates in the United States, health disparities persist across racial/ethnic groups. This review first identifies the major racial/ethnic groups in the United States. Second, the interaction between race, poverty, and death rate disparities is discussed. Finally, there is a call for further research to better understand factors that contribute to the large and persistent gap in mortality between racial/ethnic minorities and the white majority population.

U.S. Major Racial and Ethnic Groups

According to the 2000 U.S. Census, the racial/ethnic makeup of the American population was 12% African Americans, 3.6% Asians, 0.1% Native Hawaiians and Other Pacific Islanders, 0.9% American Indians and Alaska Natives, 13.3% Hispanics, and 70% non-Hispanic whites. Most blacks have ancestors who were African natives brought to the Americas as slaves. Other blacks belong to newer immigrant African groups from the Caribbean, Haiti, or other areas in the West Indies and South America. Asian immigrants came from more than 30 countries of origin in the Far East, Southeast Asia, or the Indian subcontinent. Native Hawaiians and Other Pacific Islander populations are from Hawaii, Guam, Samoa, or other Pacific Islands, while Hispanic or Latino Americans are people of mixed racial heritage who come from Cuba, Puerto Rico, Mexico, or other countries of Central and South America. American Indians and Alaska Natives are a relatively small but growing segment of the U.S. population and are native to North, South, and Central America. Non-Hispanic whites are people who immigrated to the United States from Europe, the Middle East, or North Africa. Currently, white Americans form the numerical majority in the United States, and collectively are better educated and economically situated than other racial/ethnic minorities, with the exception of Asian Americans.

Health Disparities by Race

It was long thought that racial health disparities were due to genetic differences in human populations. However, recent developments in the fields of genomics and medicine have shown that racial groups are more alike than different. Therefore, a focus on biology to explain health disparities underestimates the role that social, political, and environmental structures contribute to health outcomes. The life expectancy of most racial/ethnic minorities is shortened by social and economic inequalities and injustices that make for harsh

living conditions and exposure to racism, prejudice, discrimination, violence, and poverty.

The Interaction of Race, Poverty, and Mortality

Research has indicated that health care and health status in the United States are stratified by income, race/ethnicity, education, and occupational status. Educational attainment and high socioeconomic status are positively correlated with health and mortality advantage, whereas low socioeconomic status and poverty are linked to health disadvantage. Poverty is strongly associated with mortality among racial/ethnic minorities, who are often living in substandard housing; experiencing high rates of unemployment or underemployment, often with inadequate or no health insurance; and are often victims of violent acts, drug use, and other threats to personal health and well-being. Area-of-residence studies consistently link high mortality with high-crime areas, high crime being more likely to occur in low-income communities.

Studies of poverty trends by race show that over the life course 9 of every 10 blacks will have been exposed to poverty in the first 6 years of life, while slightly more than one half of the white population will spend 1 year of their adulthood at or below the level of poverty. Studies of older racial/ethnic groups show that 72% of older white people have earned a high school diploma, compared to 44% of blacks, 21% of Hispanics, and 65% of Asians.

African Americans and American Indians/Alaska Natives have experienced more extreme poverty than have other racial/ethnic groups. Individuals who experience no poverty in their lifetime live, on average, 10.6 years longer than those who experience bouts of poverty. Poverty increases mortality risks for entire families when there are insufficient resources to stabilize health-promoting routines, such as meal preparation, rest and sleep, exercise, and necessary support systems.

Disparities in Racial/Ethnic Mortality Rates

Non-Hispanic whites are typically used as a baseline for comparing racial/ethnic health and death disparities. Disparities exist in the area of life expectancy, with African Americans dying at higher rates and at a consistently higher level across the life span in comparison to whites and other racial/ethnic groups. Life expectancy for whites is about 7 years longer than for black Americans. African Americans are more than twice as likely as whites to die in infancy and in the age group 20 to 24. Black men and women die of cardiovascular disease and stroke more than any other diseases. The prevalence of hypertension in African Americans in the United States is among the highest in the world. Compared with whites, African Americans develop high blood pressure earlier in life, have higher blood pressure readings, and experience more complications. Risk factors for heart disease include diabetes, high blood cholesterol levels, high blood pressure, obesity, physical inactivity, and tobacco use. African Americans tend to have two or more of these risk factors as compared to whites. African American women have a higher prevalence of cardiovascular risk factors than white women of comparable socioeconomic status. African American women without a high school education have a higher prevalence of obesity compared to white women of similar educational status.

The major causes of death for Hispanics are heart disease, cancer, and accidents. With the exception of Hispanic young adults ages 20 to 24, no significant differences exist in mortality when compared to non-Hispanic whites. This finding is the opposite of what would be expected since research links mortality to low socioeconomic status and limited access to health care. Several hypotheses are proffered to explain Hispanics' mortality advantage or tendency to have consistently lower death rates than non-Hispanic whites; these hypotheses include lower age-specific death rates at older ages; underreporting of Hispanic origin on the death certificates; healthy migrant effect, which suggests that persons with good health are more likely to immigrate; and "salmon bias," the tendency of many Hispanics to return to their country of origin when ill or to die. The literature also suggests that the Hispanic advantage is associated with the large number of new immigrants found within this population and the tendency of immigrant groups to settle in communities that perpetuate cultural traditions with more naturally occurring networks that provide financial, social, and emotional support. The capacity to retain one's language and strong social networks

are protective factors that promote resilience and buffer the negative effects of external social forces linked to mortality.

Similarly, Asian Americans show a mortality advantage when compared to whites and other racial/ethnic groups, regardless of age. The major causes of death for Asian Americans are cancer, heart disease, and stroke. Asian American women have the highest life expectancy, and as a group, Asian Americans have the highest household income and percentage of college graduates of all racial groups, which may in part account for the mortality advantage. However, researchers express concerns about the reliability of current findings associated with the mortality advantage because of the large number of foreign-born Asians, the healthy migrant effect, the salmon bias, and the prevalence of underreporting in the federal census data. And there are disparities in health and death rates within the diverse Asian American population. Particularly puzzling are the extremes that show that Indian women who have resided in the United States for a long period of time do not share the advantage, whereas the Vietnamese, who have the lowest socioeconomic status, have a greater health advantage than other subgroups of Asians.

Underreporting of personal and health information by American Indians and Alaska Natives and limited access to their medical records have caused problems in linking health and mortality within and among these population groups. Systematic health information has been collected only for American Indians and Alaska Natives residing on federal reservations; these data show they experience high mortality compared to whites. For Native Americans age 65 years and older, mortality

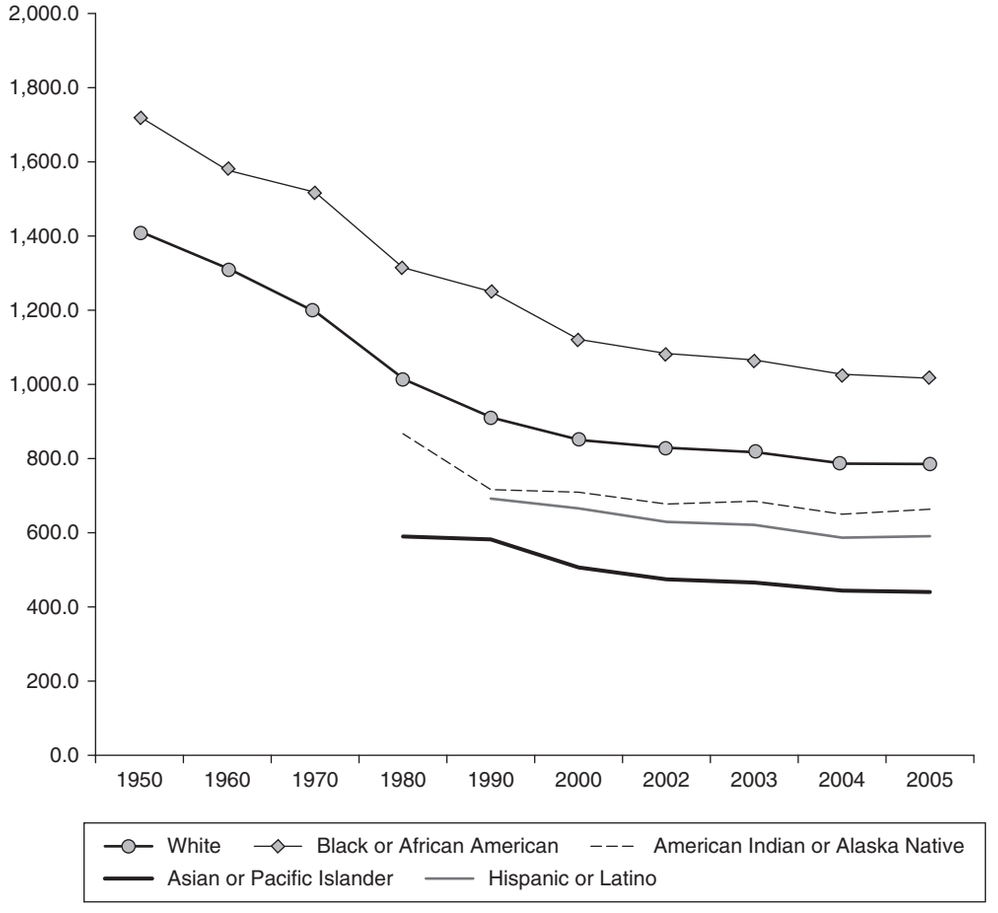

Figure 1 Age-Adjusted Death Rates for All Causes of Death, by Race and Hispanic Origin: United States, Selected Years, 1950–2005

Source: National Vital Statistics Reports, *56*(10), Table 1.

is 40% higher; among infants, 60% higher; and among young adults, ages 20 to 24 years, almost twice as high as for whites. This population has disproportionately high death rates for unintentional injuries and suicide. In addition, this group has higher rates of cigarette smoking, alcoholism, and diabetes. High rates of mortality and morbidity (chronic illness) within the Native American and Alaska Native populations are correlated with their overall low educational attainment, poverty, geographic isolation, poor access to health care, and cultural differences.

Figure 1 compares age-adjusted death rates for all causes of death, by race and Hispanic origin, for the United States for selected years from 1950 to 2005. Age-adjusted death rates are based on a standardized population of 100,000 people. The figure confirms that age-adjusted death rates for all causes have decreased for all racial/ethnic groups since 1950, with a more gradual decline since 1980. Although current research fails to fully explain all the factors that contribute to high death rates in some groups versus others, these data highlight the differential impact that multiple factors seem to have on the relationship between race and death.

In sum, many factors predispose people to mortality, including genetic variations, environmental exposures, health behaviors, socioeconomic status, psychosocial stresses, limited resources, stereotyping, discrimination, and lack of access to health care. For nearly every disease tabulated by the Centers for Disease Control and Prevention, the non-Hispanic whites live healthier and longer than do most minority populations.

Penelope J. Moore

See also Causes of Death, Contemporary; Infant Mortality; Life Expectancy; Mortality Rates, U.S.

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Reincarnation

Reincarnation is the belief that individuals are somehow able to survive bodily death by taking birth again in another form. A belief in reincarnation is universal and persistent, found in various versions on nearly every continent from ancient times to the present day. Evidence supports nearly equal antiquity of belief in reincarnation in Africa, Asia, Europe, and the Americas. Because a complete list of the numerous religions and philosophies, ancient and modern, which affirm some form of reincarnation would be too large a subject to cover in this entry, the following necessarily treats the topic selectively, not comprehensively. The views selected represent the wide-ranging versions and variations of belief in reincarnation from ancient times to the present throughout the world, in particular, in India, Ancient Greece, Africa, the British Isles, and North America.

India

At least as early as the 8th century B.C.E., the idea of reincarnation appeared in the Upanishads, part of the authoritative revelation of reality for most Hindu religious and philosophical traditions. Reincarnation is described there metaphorically in this way: As a caterpillar inches its way from the leaf of one plant onto the leaf of another plant, so

the soul leaves behind one body and crosses over into a new one.

Birth and death are recurring events that punctuate the beginningless and endless cyclical syndrome known to indigenous Indian religions (Hinduism, Buddhism, Jainism, and Sikhism) by the Sanskrit term *samsara*, meaning flows together or wanders. Samsara metaphorically pictures the incessant flow of the simultaneity of birth and death, with people at every moment entering and exiting the world, wandering from one birth to another in search of liberation and release from the otherwise beginningless and endless repetition of reincarnation. Hence philosophically speaking, reincarnation is a predicament, not a solution. Philosophically speaking, birth is a mistake but it can be corrected through liberation from the cycle of birth and death.

The desire for liberation has never been normative or popular in India but ideal and exceptional. More popular aims of life are of equal religious legitimacy, including the pursuit of sensual, aesthetic, and sexual pleasure, and the ambition for social success in the form of material wealth, prestige, and power. Most Hindus seek meaningful lives pursuing pleasure and success and take consolation in the doctrine of reincarnation. For them reincarnation promises that death is not the end and provides unlimited opportunities to experience the innumerable pleasures and to pursue promising prospects of social success. However, to those exceptional individuals in each generation of Indian society who seek liberation above all else, the very same doctrine of reincarnation presents a problem to overcome, not a therapeutic remedy for human anxiety about facing finitude. The person who transcends reincarnation discovers the deep innermost self known as Atman, the birthless, deathless, changeless ultimate Self underlying all of the changing personalities that take repeated births until the true Self (Atman) is realized.

The doctrine of reincarnation in India also addresses and answers the psychological need to provide an explanatory account of the world that satisfies the human desire for justice in the universe. By doing good, a person becomes good; by doing bad, a person becomes bad. Reincarnation functions as a cultural vehicle of social cohesion in India. Far from instilling fatalistic attitudes, the doctrine of reincarnation, which is governed by the principle of karma, serves as a powerful motivation for good moral behavior and exerts a restraining influence on antisocial impulses and inclinations. Reincarnation is driven by the principle of karma, which asserts that all human volitional actions engender results that the performer of the actions must live to face and experience somewhere, sometime, somehow—in pleasure or pain—sooner or later in this life or a future reincarnation. For example, the ancient code of Manu warns that a student who depends too much on the teacher for material support will be reborn as a worm, and the one who speaks disparagingly about the teacher, even though the teacher may warrant it, will be reborn as a bug. People obsessed with food and driven by gluttony are reborn as pigs.

Early forms of Buddhism in India delineated six realms of reality through which beings are constantly recycled unless and until they realize nirvana (the extinguishing of desire for separate and permanent existence). The six realms were all present in pre-Buddhist Indian cosmology, but Buddhists approached it from a different perspective, situating them in the center of the wheel of becoming, also known as the twelvefold chain of causation or the doctrine of interdependent origination. This doctrine explains how all things exist, not as separate and enduring things in themselves, but merely as processes in utter interdependence. The six realms into which reincarnation can occur include gods in heaven, animals and humans on earth, and hungry ghosts and demons in hell. For both Hinduism and Buddhism, neither heaven nor hell is eternal or irrevocable—rather, both are temporary abodes in which pleasure or pain is experienced for a length of time commensurate with one's actions in prior human existences.

Buddhism historically denied the existence of an unchanging eternal self yet maintained belief in reincarnation. If there is no self, what exactly gets reincarnated? The fundamental will to be, to exist, to grow, to become more and more is the most powerful force in the universe; it is this energetic will to be that incarnates itself repeatedly until the will to be is extinguished in the realization that to be or not to be is neither the question nor an option. Existence entails change and whatever does not change does not exist. Unlike the liberation (*moksha*) of Hinduism—which escapes the realm of change to encounter the changeless, birthless,

deathless reality of Atman—Buddhist nirvana entails the practical awareness that there are no persons, places, or things that possess the characteristics of independence and permanence. For enlightened people there is no difference between samsara and nirvana; samsara is existence lived in ignorance about how things really are, entangled in the imagination that things are separate and enduring; in contrast, nirvana is existence lived in the experiential awareness of the emptiness that leads to detachment.

While escaping reincarnation was an agenda for early Buddhists, the later and larger development in Buddhist thought, known as Mahayana, produced a new ideal that enlightened ones (bodhisattvas) take a vow to be reincarnated continuously unless and until everyone becomes enlightened. Hence the meaning of the Mahayana slogan that there is no nirvana apart from samsara. There is nowhere else to go outside of the six-samsaric realms of suffering to experience nirvana.

Ancient Greece

Ancient Greeks held versions of reincarnation at least as early as the 8th century B.C.E. Metempsychosis, or transmigration of the soul as it was also known to Greeks, was made popular by Pythagoras, the famous 6th-century B.C.E. mathematician. Pythagoras's version of reincarnation was situated in a different cosmological context than that of India. Rather than seeking escape from the rounds of reincarnation, Pythagoras held that the goal of life was to exist within the cosmos in a state of intellectual alertness and emotional peace and to live in harmonious microcosmic relation to the macrocosmic universe. By ascetic and ethical practices such as vegetarianism, a person could purify the soul for an improved rebirth on earth as a person and avoid regressing to rebirth as an animal. Earlier than Pythagoras, the 8th-century B.C.E. religious society known as the Orphics espoused a version of reincarnation strikingly similar to some found in India. Orphics believed in a divine origin of the soul, which became imprisoned in the body from which it seeks ultimate release through a series of incarnations culminating in liberation from bodily form and return to its original divine status. Empedocles, the 5th-century B.C.E. Greek philosopher, claimed to have lived the lives of a boy, girl, bush, and a fish. Plato and Socrates also entertained and employed theories of reincarnation as rhetorical devices in their advocacy of a life lived as a philosopher in pursuit of virtue and wisdom.

Africa

Some African traditions hold distinctive versions of reincarnation, which may be described as partial and limited reincarnation. Reincarnation is limited because people are only reincarnated as humans and only within one's own family. The reincarnation is partial because only some distinguishing physical features or personality traits reincarnate into a descendent, but the essential individuality of the person is preserved as distinct, autonomous, and independent of the descendent into whom only some traits have passed. The Yoruba epitomize and dramatize one paradigmatic African version of reincarnation in the names given to their newborn children: Iyabo—mother returns; Yetunde—mother comes back a second time; Babatunde—father has come again; Omutunde—child comes back again. The transmission of vital lineage character traits ensures the continuity and perpetuation of the family and clan in whose interest reincarnation serves to preserve collective, not individual, identities.

British Isles

European versions of reincarnation are even more partial and limited than African ones. Celts of the British Isles restricted reincarnation to divinities and heroes; there is no evidence for mortal reincarnation. Divinities can transmigrate into forms ranging from insects or worms and birds to herds of varying animals, even to children. According to one myth, Etain, a goddess, was an insect who fell into a cup of wine from which she was swallowed by Etar. Eventually Etain was reborn as a child who had no recollection of existing as a goddess in her past life. Divine amnesia is also a common Hindu motif for explaining the descent of divinity into humanity. The divine becomes human and, having forgotten its transformation, the human seeks to rediscover its true divine identity. The similarity of this motif in the Celtic and Hindu traditions brings us full circle from East to West

and back to a meeting in the middle, where the Indo-European origins of Celtic and Hindu ideas of reincarnation are blurred in the never completely settled dust of antiquity.

Modern North America

One important foundation for the popularization of reincarnation in modern North American New Age religions was established in New York City in 1875 by Helena Blavatsky, a Russian immigrant to America who founded *theosophy*, an eclectic philosophy integrating elements of Eastern and Western religions. The theosophical doctrine of reincarnation espouses a progressive evolutionary development of the soul through a series of reincarnations. The soul is always learning in order to move forward toward ultimate transcendence of bodily existence and to return to an original pristine and primordial bliss.

New Age religions' popularization of belief in reincarnation gave birth to a new field of parapsychology called past life therapy. Past life therapy employs clinical hypnotherapy to facilitate memories of an unconscious past life, emotionally traumatic experiences, and psychological or interpersonal conflicts. Under the guidance of a trained therapist, some Americans pursue New Age visions of wholeness by recalling, investigating, reconciling, and resolving repressed memories from previous lives.

From ancient India to modern Indiana and everywhere and at all times in between, various versions of reincarnation have persisted in addressing and answering basic human social and psychological concerns. Human beings have universally and persistently experienced anxiety about facing finitude and generally do not favor ambivalence or ambiguity; instead, they prefer clarity and certainty, especially in matters of such momentous existential concern as death in human experience. Beliefs in reincarnation are as diverse as the cultural religious imaginations that conceived them, ranging from interpreting rebirth as a mistake that can be corrected, on the one hand, to celebrating rebirth as a reward for a noble past life, on the other. Depending on the particular cultural religious context, reincarnation may be a good thing or a bad thing. Regardless of whether reincarnation is viewed positively or negatively, belief in reincarnation serves a psychologically and existentially therapeutic purpose, namely that it provides meaning for the pursuit of individual and collective corporate human wholeness, fulfillment, completion, and perfection.

William C. Allen

See also Buddhist Beliefs and Traditions; Immortality; *Tibetan Book of Living and Dying, The*

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Resurrection

Resurrection means rising from the dead. The word comes from Middle English, Anglo-French, and Latin (from *resurrectio* "the act of rising from the dead," from *resurgere* "to rise from the dead," from Latin *re-* "again" + *surgere* "to rise"). The word *resurgence* has similar roots. The best-known example of resurrection would be the resurrection of Jesus Christ. This is seen by Christians as a model for the resurrection of all dead humans that will take place before the final judgment. *The Catholic Encyclopedia* defines *resurrection* as "rising again from the dead, the resumption of life." This last part makes a distinction between resurrection and reincarnation—which would see the lifeforce or soul move to a new life rather than resuming a previous one.

Egyptian and Zoroastrian Beliefs

Perhaps the first reported resurrection was that of the Egyptian god Assur (later called Osiris by the Greeks). The story is told that Assur was on a trip abroad and left his kingdom in the care of his wife, Isis. As he was returning to the Nile Delta from one of these trips, Assur was murdered by the evil

god Set. His body was hacked into pieces and the parts were scattered. Isis found and gathered the body parts of Assur, put them back together, and resurrected Assur from the dead. She then joined with Assur and their union produced a son, Heru. Assur/Osiris became king of the afterlife. Isis became the earth-mother (and the first "Eve"). Heru was the first pharaoh to whom all other pharaohs traced their ancestry and from whom they received their divinity and immortality.

The earliest discussion of general resurrection can be found in the teachings of Zoroaster between the late 7th century and early 6th century B.C.E. Zoroaster taught that each individual would be judged at the end of life, but at the end of the present world order there would be a general resurrection of all dead humans and, at that time, a fire would cover this world and the next and separate the evil and the good. The evil would be consumed by the flames. The good, or righteous, would not be harmed by the fire because they had no evil in them and no need to be purified by the flames. At that time Angra Mainyu and his devils would be driven away forever. The idea of resurrection remained a part of Zoroastrian belief and influenced the followers of other religions, including Judaism.

Resurrection and Jewish Belief

The Sadducees (the clan that provided the priests for the Jews) sought to purify Judaism and rejected beliefs they felt were counter to the teachings of the Torah, and the five books of Moses in particular. One of these rejected ideas was the belief in the resurrection of the body to "full consciousness" in the afterlife. For the Sadducees to want to reject it, the belief in resurrection must have been present in Jewish thought of the time. Even today, among the 13 cardinal principles of the Jewish faith is the final one, which says that a Jew reciting the cardinal principles believes with perfect faith that there will be a resurrection of the dead. In the Orthodox Union translation, Principle 13 says, "I believe with perfect faith that the dead will be brought back to life when G-d wills it to happen." This statement seems consistent with the beliefs concerning resurrection in Zoroastrianism. When Reform Judaism was growing in the mid-19th century, references to belief in the Messiah and the resurrection of the dead were dropped from their Sabbath service, leaving belief in resurrection as an Orthodox tenet.

The Torah/Old Testament contains several passages that speak of resurrection. In 2 Maccabees one of the martyrs says that if his body is taken from him, it will be restored again (12:11; cf. 9:14). The Book of Daniel (12:2; cf. 12) mentions the same belief. Ezekiel (37) shows the belief in a literal resurrection, and Isaiah says that "dead men shall live, my slain shall rise again . . . the earth . . . shall cover her slain no more" (26:19–21). Finally, Job was strengthened by the thought of the resurrection of his body: "As for me, I know that my Redeemer lives, and at the last He will take His stand on the earth. Even after my skin is destroyed, yet from my flesh I shall see God whom I myself shall behold and whom my eyes will see and not another. This hope is laid up in my bosom" (Job 19:25–27).

Resurrection Belief Among Christians

Early Christians held belief in resurrection from the beginning of the faith. Christian writings about resurrection date back to Saint Paul, circa 57 C.E. However, the resurrection that Paul spoke of may have been a "spiritual" resurrection. Paul said that a physical body could not enter heaven since it was bound to decay and decay could not share in a state that was eternal. Paul described some who had witnessed the resurrected Christ as "having fallen asleep." They spoke of death as "going to sleep" until the final day of judgment. Christian Scientists use the word *resurrection* to describe a "spiritualization" of thought, since matter is seen as illusion. Belief in the material leads to a spiritual understanding. Contemporary Christian Science teaches that Christ did rise from the dead in both spiritual and physical form. The idea of spiritual resurrection causes some difficulty. The soul is said by Christians to be immortal. As such, it cannot "return" to life because it is immortal and does not die. It is only the physical body that dies and can be resurrected with a "return" to life.

The biblical account of spiritual resurrection offered by Paul does not agree with the accounts of Luke and John. They saw the resurrection of Jesus as a physical event, with the body and soul reunited. This belief is contained in the Apostles' Creed, a statement of basic Catholic belief, which says, "I

believe in . . . the resurrection of the body and life everlasting." Martha, Lazarus's sister, showed her Jewish belief in resurrection when she said to Jesus, "I know that he [Lazarus] shall rise again, in the resurrection at the last day" (John 11:24).

There is a distinction between the resurrection of Jesus and the general resurrection promised to Christians. After the apparent differences among biblical accounts are set aside, there is agreement on a number of points regarding the resurrection of Jesus. These points include the belief that after his resurrection, Jesus appeared to one or more people.

- In his gospel, Matthew describes Jesus's appearance to holy women and again on Mount Galilee.
- Mark says Jesus was seen by Mary Magdalene, by the men on the road to Emmaus, and by the 11 remaining apostles before his ascension.
- Luke describes Jesus's appearance on the road to Emmaus, to the disciples in Jerusalem, and to Peter.
- John speaks of Jesus's appearance to Mary Magdalene and 10 of the Apostles (all but Thomas) on Easter Sunday.
- Paul tells of the appearance of the risen Jesus to Cephas, to the 11 Apostles, to 500 believers, and to Paul himself.

The Story of Lazarus

Another example of Christian belief in resurrection is the story of Lazarus. Lazarus died and, at Jesus's command, was said to have been raised from his tomb with body and soul united. This resurrection took place 3 days after Lazarus's death. The time interval is important because Jews did not believe the person was truly dead for the first 3 days and because it was a symbolic prediction of the time spent by Jesus in the tomb after his death on the cross. This story was used as an example of the reward—triumph over death—that was offered to all Christians who believed in the teachings of Jesus.

Proving Versus Defining Resurrection

Theologians who believe in resurrection do not typically attempt to prove it and limit themselves to defining it. The existence of general resurrection seems unable to be proven by reason alone. It is accepted in a number of religious traditions as an article of faith (belief without concrete proof). However, there are some ideas that believers point to as supporting belief in resurrection; these are the following:

- The lifeforce, or soul, and body have existed together from the start of the individual's life, and a permanent separation would seem unnatural. This point can be seen in Matthew 22:23–32.
- The body joins the soul in all its deeds, both good and evil. Therefore it seems fair and just that the body share in the soul's reward or punishment (see 1 Cor. 15:12 and 2 Thess. 1:4).
- The separation of the soul and body seems to leave the soul "incomplete." If that is true, the completion of the person's happiness in eternal reward seems to demand the resurrection of the body. Jesuit priest and philosopher Pierre Teilhard de Chardin took this argument one step further and said that the person's world would also rise again, or fall, with the individual and that animals and nature would also be resurrected to complete the individual.

The Bible has many images of life being restored not only to dead people but to things in nature as well. The latter can be seen in the blossoms that sprang from Aaron's staff, the grain of seed dying and springing up again, the symbolism of the egg, the seasonal cycle of the year, and the succession of day and night. These images appear in early Christian art. However, Christian theologians are more inclined to believe that without divine intervention, in nature there would have been no resurrection of the body.

The Resurrected Body

Like creation, resurrection is seen as a work of God. However, the body is said to be transformed by resurrection, since it would now be immortal. The just will enjoy endless happiness in their restored bodies, while the wicked "shall seek death, and shall not find it, shall desire to die, and death shall fly from them" (Rev. 9:6). Every resurrected body is said to now share the characteristics of identity (individuality is maintained), entirety (the body is complete in a glorified state), and immortality. Catholics, and some other Christian

traditions, share a belief in other qualities. These are the following:

- Impassibility: The resurrected body is beyond the touch of any pain or suffering.
- Brightness/glory: The saints are said to "shine like the sun," and the body, though a glorified *physical* object, becomes more like the spiritual soul it has rejoined.
- Agility: The chosen are referred to as "the quick" and can move as fast as the soul desires.

Ideas and projects, like people, can also be "resurrected"—brought back to life in a metaphorical sense. In this regard the word takes on a secular meaning to accompany its religious meaning.

There are numerous beliefs concerning resurrection, and there is much misunderstanding as well. As Madigan and Levenson point out, Christian belief in resurrection is deeply rooted in the Jewish faith and culture from which Jesus emerged. It is not Christianity moving out to a new life from an earth-bound Judaism. It is a belief that would see all people resurrected together. For that reason it is not really an individual concept, because in both Judaism and Christianity it describes a collective resurrection of all people at the end of time.

In contrast to reincarnation, something to be "escaped" through a final release from the cycle of birth, life, decay, and death, resurrection is seen as a positive image—at least for the just. For those who believe in the positive future offered by resurrection, it can provide optimism, even in the most difficult of times. A belief in resurrection can allow even those people in despair to believe that every life can continue and that it can "end" on a positive note—a final reward for a life well lived.

Robert Stevenson

See also Christian Beliefs and Traditions; Eschatology; Eschatology in Major Religious Traditions; Hell; Immortality; Jewish Beliefs and Traditions; Last Judgment, The; Reincarnation; Soul

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Resuscitation

Resuscitation signifies the act of returning an individual to life from an unconscious or death-like condition. The fundamental distinction between life and death is universally acknowledged, but the notion of reversibility of death varies greatly across cultures and time. The spirituality of many cultures frequently incorporates ideas of the immortality of the soul and occasionally the body as well. Western civilization's emphasis on the opposing duality of spirit versus body has determined that resuscitation be relegated to the realm of physical phenomena. Resuscitation is best understood in its historical, medical, cultural, legal, and ethical contexts.

The dependence of life on the flow of air and blood has been recognized in many cultures for thousands of years. There is evidence that resuscitative techniques, including attempts to restore circulation and breathing, were utilized at least back to biblical times in the Near East. Resuscitation in modern societies is viewed principally within a medical framework. Progressive scientific understanding and manipulation of normal and abnormal human physiology have achieved the reversibility and prevention of many diseases. The development of cardiopulmonary resuscitation (CPR) in the 1950s was based on decades of research using animal models. Initially CPR was intended for patients in hospital settings, but its use has been expanded to out-of-hospital settings as well. Medical resuscitation began with basic mechanical restorative interventions, but it has grown to encompass sophisticated electrical and pharmacological modalities.

Resuscitation Procedures

Currently there are widely agreed upon resuscitation procedures for witnessed and unwitnessed

cardiopulmonary arrests. Initial efforts include (a) chest compressions to approximate the pumping of the heart and (b) mouth-to-mouth breathing to provide oxygen and allow exhalation of carbon dioxide. These procedures restore, at best, 60% of normal physiological function. Trials of mechanical chest compression devices have not demonstrated significant improvement over chest compressions performed manually. Mechanical ventilation with oxygen-enriched air after placement of a tube in the trachea, however, clearly has advantages over mouth-to-mouth breathing. The interdependence of respiratory failure and cardiac standstill requires that resuscitative efforts be directed toward *concurrent* restoration of respiration and circulation.

Scientific investigation into the immediate causes of cardiopulmonary collapse has revealed several potential antecedents: inability to move or exchange oxygen and carbon dioxide, cessation of electrical activity within the heart, ventricular fibrillation (disorganized electrical activity leading to ineffective heart pumping), and mechanical interference with the pumping action of the heart. For out-of-hospital cardiorespiratory collapse, the most common cause is disordered ventricular electrical activity. Reversal of the cause is currently the goal of advanced life support. Ventricular fibrillation, for example, may be reversed by electric shock applied externally to the chest. Because of the rapid accumulation of noxious metabolic products during periods of absent or inadequate cardiopulmonary function, pharmacological interventions are also required. Asystole (absence of cardiac electrical activity) and electromechanical dissociation (pulseless cardiac electrical activity) have proven more resistant to current therapeutic modalities.

Outcomes of Cardiopulmonary Resuscitation

The original intention of CPR was restoration of adequate respiration and circulation as a *temporizing* measure, allowing treatment of the underlying condition(s) causing the arrest. Ultimately, cessation of respiration and circulation is the final event in all dying processes, but underlying conditions have significant influence on the success of resuscitative efforts. Coronary artery disease and associated cardiac electrical disturbance are the most common underlying diagnoses resulting in cardiopulmonary arrest. Modification of certain risk factors such as elevated cholesterol and hypertension has been demonstrated to delay or prevent coronary artery disease and concomitant decrease in arrests. Installation of permanent antifibrillatory devices has lowered the risk of arrest in many patients.

In the industrialized world, awareness and availability of CPR have continued to increase, but clinical outcomes are consistently suboptimal. Between 5% and 20% of resuscitated patients (both in-hospital and out-of-hospital) can be expected to survive. Because brain function is highly dependent on adequate oxygen delivery, it has become apparent that CPR could be successful in restoration of cardiopulmonary function, but temporary or permanent brain damage might result. Of those who survive resuscitation, at least 50% have temporary or permanent neurological dysfunction.

Outcomes depend on many factors: expertise and experience of the initial responder, existence of coordinated systems conveying a patient to the hospital for emergent care, presence of coronary artery disease, type of cardiac electrical malfunction, and degree of reversibility of underlying diagnosis. A significant portion of health research is devoted to improving resuscitative techniques as well as coordination of systems promoting efficient delivery of these technologies both in and out of hospital.

Do Not Resuscitate

Western civilization has strongly emphasized the value and importance of life; consequently, death is frequently perceived as intrinsically evil. Consistent with this orientation, legal and medical institutions of most countries favor the preservation of life whenever choices can be made. Nevertheless, in the past 40 years legalization of abortion in the United States and physician-assisted suicide in Oregon have somewhat countered these policies. The high value placed on personal autonomy in Western civilization has prioritized legal recognition of the right to choose or refuse medical interventions, including CPR. Although the default in medical environments is maximal effort toward preservation and prolongation of life, most technologically advanced societies allow an individual (or surrogate) refusal of any medical intervention even though death is likely to result. Modern societies have begun to confront conflicting medical,

ethical, and legal imperatives amid rapidly advancing resuscitation technology and slowly improving outcomes.

James Brandman

See also Life Support Systems and Life-Extending Technologies

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Right-to-Die Movement

Although interest in end-of-life issues has waxed and waned during the 20th century, a recent resurgence of public attention to this topic has occurred in the United States. Specifically, a host of social and cultural forces have spurred an effort to legalize terminally ill patients' rights to control the manner and circumstances surrounding their death. Factors such as the rapid growth of medical technology and an increased emphasis on personal autonomy have given rise to the right-to-die movement. This large-scale social initiative has advocated for the right of terminally ill patients to refuse medical treatment, to forego life-sustaining technology, and to request options such as physician-assisted suicide and euthanasia.

Although some scholarly discussion of individuals' right to die appeared as early as the 19th century, the right-to-die movement in the United States did not emerge as a significant social force until the 1970s. The event that pushed right-to-die issues to the forefront of public attention was a New Jersey Supreme Court ruling concerning patients' rights to withhold life-support intervention. The case, known as *In re Quinlan,* was instigated by Karen Ann Quinlan's parents, who fought for the legal right to discontinue their daughter's life support. After considering the Quinlans' arguments, the New Jersey Supreme Court ruled that patients and their surrogates have a right to refuse unwanted medical treatment, even if this action hastens the patient's death. This ruling established a legal precedent for patients' rights to refuse life-support interventions. It also had a dramatic impact by instigating statewide legal action supporting the use of advanced directives. Finally, *In re Quinlan* drew tremendous social attention, bringing end-of-life issues to the forefront of public discussion and giving momentum to the right-to-die movement.

Taking advantage of the public attention raised by Quinlan's case, in 1980 the British journalist Derek Humphry founded the Hemlock Society, a right-to-die organization that aimed to further expand patients' options near the end of life. Specifically, Humphry argued that terminally ill patients should not only be able to refuse unwanted medical treatment but also to request active aid-in-dying by means of assisted suicide and euthanasia. The foundation of the Hemlock Society marked a shift in attention from refusal of treatment to the legalization of physician-assisted suicide. Over the next 2 decades, the Hemlock Society became a major force in the right-to-die movement and spurred efforts to legalize assisted suicide at the state and national levels. It was soon joined by other right-to-die groups, such as Compassion in Dying, which was founded in 1993 in Washington State.

During the 1990s, the Hemlock Society and Compassion in Dying made considerable efforts to legalize aid-in-dying and to decriminalize assisted suicide. In 1990, the Hemlock Society sponsored Washington State's Initiative 119, the first state referendum asking voters to decide on the issues of legalizing physician-assisted suicide. The Washington State initiative was quickly followed by a similar referendum in California. However, the

majority of voters in both states refused to support the proposed measures. Oregon became the first state to endorse the legalization of physician-assisted suicide, with the passing of the Death With Dignity Act in 1994.

At the same time that right-to-die advocates were making organized efforts to legalize assisted suicide in several states, Jack Kevorkian, a Michigan medical pathologist, announced that he had assisted in the death of a middle-aged woman diagnosed with Alzheimer's disease. In this case Kevorkian used a "mercitron," a suicide machine he had created, to allow the self-administration of a lethal mixture of drugs. Between 1990 and 1998, Kevorkian publicly advertised his aid-in-dying services and eventually assisted in the death of at least 93 patients. Despite existing evidence, Michigan courts acquitted Kevorkian of charges for assisted suicide and murder on three occasions. Finally, in 1999 Kevorkian was found guilty of second-degree murder after performing euthanasia on a 52-year-old man with Lou Gehrig's disease.

While Kevorkian's radical approach to assisted dying was causing considerable social and legal debate, another medical professional, Timothy Quill, went public about his involvement with assisted suicide. In 1991, Quill published an article describing his assistance in the suicide of "Diane," a terminally ill patient with leukemia. Quill had been Diane's attending physician for 8 years and was aware of her values of personal autonomy. When asked to assist in controlling the circumstances of Diane's death, Quill discussed alternatives with her, such as palliative care and aggressive pain management, but each method was rejected as inconsistent with the patient's desire to maintain dignity and control. Eventually Quill agreed, providing Diane with a prescription for a lethal dose of barbiturates. Three months later, after experiencing periods of severe pain and physical deterioration, Diane consumed the medication prescribed by Quill. Quill's admission that he had assisted in the death of his patient received significant attention in the medical community. Although his story did not receive the same level of media coverage as Kevorkian, Quill has become one of the most influential advocates of the right-to-die movement in the medical community.

Kevorkian's and Quill's open statements about assisting in the suicide of terminally ill patients attracted wide public attention to the issue. This focus on assisted suicide was accentuated by two U.S. Supreme Court cases, *Vacco v. Quill* (1997) and *Washington v. Glucksberg* (1997). These cases challenged existing state statutes that criminalized assisted suicide and sought to establish a constitutional right for assisted suicide in the case of terminal illness. The U.S. Supreme Court heard both cases simultaneously but refused to recognize a constitutional right to assistance in dying by suicide. The Court distinguished between refusing medical treatment and providing assisted suicide, supporting patients' rights in the first case but not in the second.

Although the Supreme Court ruling was a defeat for right-to-die activists, it did not foreclose future discussion of end-of-life issues. In a footnote, the Supreme Court specified that it would be open to hear right-to-die cases in the future. In addition, the Supreme Court allowed the states to develop their own laws regarding assisted suicide. Thus, although the Supreme Court refused to grant terminally ill individuals a constitutional right to seek assisted suicide, it did not prevent the states from making their own decisions on the issue.

In the aftermath of these Supreme Court rulings, the right-to-die movement underwent a period of transition. In 1992, Derek Humphry retired from his leadership position in the Hemlock Society, which led to a series of internal organizational changes. In 2003, the society's board of directors voted to change the name of the Hemlock Society to End of Life Choices. In 2005 End of Life Choices and Compassion in Dying merged to form Compassion and Choices. The stated goal of the new organization is to promote legislative reform and expand patients' options at the end of life, including greater access to palliative care, adequate pain control, and the legalization of assisted suicide.

Although the right-to-die movement in the United States has changed in recent years, its accomplishments are clear. Court cases, such as *In re Quinlan*, established patients' rights to refuse life-support interventions and to enact advance directives. State referenda gave Americans the choice to support or oppose the legalization of aid-in-dying, and Oregon became the first state to allow physician-assisted suicide under strict regulations. Medical professionals made public

announcements about their involvement with physician-assisted suicide, and the U.S. Supreme Court debated the existence of a constitutional right for assisted suicide.

In conclusion, the history of the right-to-die movement in the United States is a narrative of both progress and challenge. In 2004, Derek Humphry reflected on the accomplishments and the future of the movement. He noted the movement's successes; however, he stressed the need for continued legislation efforts, as well as enlisting greater support from the medical community and society at large. Furthermore, Humphry advocated for eliminating the taboo surrounding assisted suicide by integrating right-to-die issues in the social and moral fabric of American culture.

James L. Werth Jr., Elena Yakunina, and Jessica M. Richmond

See also Assisted Suicide; End-of-Life Decision Making; Euthanasia; Living Wills and Advance Directives; Quality of Life

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School Shootings

School shootings are defined as events wherein a person or multiple individuals use gun violence to wound or murder members within an educational institution. These shootings are committed by a variety of people who may be either suffering from a mental illness, who are disenfranchised, current or former students, members of the staff or faculty, or outsiders in the community. There may be prior experiences of bullying or discrimination toward the shooters. The shooters end up killing or wounding their victims and often, in the end, shooting themselves. Shootings that have more than 10 victims are characterized as massacres or acts of terrorism.

History

Violence has been a part of schools as long as there have been such institutions. In the 17th century, European children routinely went to school armed with swords and guns. In the 18th century there were violent uprisings and rebellions by university students who turned their violence toward those in authority.

In 1764, the Enoch Brown school massacre was notorious because of the type of violence involved. Four Lenape American Indian warriors entered a schoolhouse where Enoch Brown, the schoolmaster, and 12 students were working. He pleaded with the warriors to leave the children alone, but they shot and scalped him and tomahawked and scalped the children. Two of the scalped children reportedly survived. Violence was initially directed toward the teachers or masters within a school, but by the 20th century the focus of the aggression began to change as students began to target other students.

Violence and shootings before the 1990s occurred most often in large urban areas; however, school shootings in the 1990s occurred in largely suburban, white, middle-class neighborhoods. The most notorious and widely publicized school massacre occurred at Columbine High School in Littleton, Colorado, on April 20, 1999. It was here that Eric Harris and Dylan Klebold, two students at the high school, brought explosives and guns into the high school and began their killing spree. They were attempting to kill hundreds with their explosives and when that didn't work, they went on a shooting rampage that resulted in the death of 12 students and a teacher; 24 others were wounded, and they killed themselves. This was the school shooting that changed policies and procedures in high schools throughout the world.

Cultural Considerations

Worldwide there are families in which work, divorce, economic situations, and the challenges of single parent homes leave children alone much of the time. Many analysts believe this condition has created an environment that fosters a culture of isolation and disconnection in those children. Many of the students who participate in school shootings spend an inordinate amount of time home alone, and it is believed that they become

Table 1 Notable Shootings: 1764–2008

Name	*Location*	*Year*	*No. of Deaths*
Enoch Brown School Massacre	Franklin County, Pennsylvania	1764	10
University of Texas Massacre	Austin, Texas	1966	17
Kent State Shootings	Kent, Ohio	1970	4
Ma'alot Massacre	Ma'alot, Israel	1974	22
Calif. State University, Fullerton Library Massacre	Fullerton, California	1976	7
Cleveland Elementary School Shooting	San Diego, California	1979	2
Cleveland Elementary School Shooting	Stockton, California	1989	6
University of Iowa Shooting	Iowa City, Iowa	1991	6
Lindhurst High School Shooting	Marysville, California	1992	4
Dunblane Massacre	Dunblane, Scotland	1996	17
Pearl High School Shooting	Pearl, Mississippi	1997	3
Heath High School Shooting	West Paducah, Kentucky	1997	3
Westside Middle School Shooting	Jonesboro, Arkansas	1998	5
Thurston High School Shooting	Springfield, Oregon	1998	4
Columbine High School Massacre	Littleton, Colorado	1999	15
Erfurt Massacre	Erfurt, Germany	2002	16
Red Lake High School Massacre	Red Lake, Minnesota	2005	10
Amish School Shooting	Nickel Mines, Lancaster County Pennsylvania	2006	6
Virginia Tech Massacre	Blacksburg, Virginia	2007	33
Jokela School Shooting	Tuusula, Finland	2007	8
Northern Illinois University School Shooting	DeKalb, Illinois	2008	6
Kauhajoki School Shooting	Kauhajoki, Finland	2008	11

shaped by the culture of the media that they and their peer groups participate in, namely television, the Internet, and violent video games. It is also suggested that violent video games may be linked to an increase in aggression among these young individuals and, in many cases, may lead to their being desensitized to violence.

Along with isolation there are issues of an abusive family situation that breeds fear and rage. Adolescents who have suffered abuse or humiliation, or students who have emotional disturbances and who spend their time alone, may choose to engage in dangerous activities to express their frustration and anger. Religion and politics may also be a factor in some countries.

In the United States, a third of all households have at least one gun, and many of the shooters involved in school shootings access their weapons from the home. Almost all of the shooters have had prior experience with firearms or have gotten the weapons used in the violent events from their own homes. The effects of graphic and gratuitous violence in video games and violence in the media seems to influence some boys in particular, associating blood and violence with winning. Many of the social pressures these children experience affect their sense of self-worth and lead them to identify themselves as victims. In turn, it is suggested the students tend to focus their internal rage outward onto others.

Identifying Factors

Effort is directed toward identifying those factors that lead school-age children and young adults to engage in such school shootings and related violent activities. At issue is the identity of the common characteristics of these individuals, and what social policies and procedures can be implemented to assist in identifying potential perpetrators of school violence. Such concerns generate a list of questions, including whether these violent individuals are genetically predisposed to this type of behavior, whether they are physiologically impaired or they are spiritually and psychologically unfit, whether those children and young adults who have already engaged in school violence are examples of ineffective and damaging parenting styles, and whether or not abuse, bullying, and the resulting isolation were cause for a dangerous disconnect from other human beings. Although there do not appear to be any clear answers currently available to assist in addressing these issues in the public domain, there is a sense that all of these may be elements that lead to these violent expressions of the rage, frustration, despair, and hopelessness that, in turn, are carried out through these horrific acts of violence. The U.S. Secret Service suggests that adults ask the following questions to avoid school shooting: What is the child saying or what has the child said? Do they have complaints? What do their friends have to say? Can they get a gun or guns? Are they suffering from depression?

Although there isn't a profile, there is a stereotype of a student who is considered to be more likely to become a perpetrator of a school shooting. White males who dress in black clothing and long black trench coats who are socially isolated and are disengaged in their academic communities serve as an example. These young boys and men spend their free time alone playing violent video games, browsing the Internet, and are often suicidal.

In trying to establish a profile of possible perpetrators of school violence, it is important to rise above the existence of the myths surrounding those who are most likely to commit school shootings. Researchers report that at present there is no accurate profile that can be used to identify a student or groups of students who will be likely to participate in school shootings. There are a variety of family structures, ethnicities, academic achievements, personalities, and school histories that influence the lives of the shooters. These factors range from seemingly stable, intact families from the middle to upper socioeconomic strata of society with students who are social and who perform well academically, to students who come from low socioeconomic households who are socially isolated and inept individuals who are less than successful in the academic environment. Students who commit these crimes are identified as being from all socioeconomic backgrounds.

It is also believed by some analysts that school shootings represent impulsive acts that are spontaneous without planning or forethought. However, events such as school shootings do require planning and gathering of weapons. One myth that has been dispelled is that no one around the shooters knew what was being planned. In almost every event, there were others who knew about previous behaviors, conversations, writings, or postings on the Internet that indicated or foreshadowed the events that would follow. Many of the adolescents had peers who knew what the shooters were thinking and planning before the shootings.

There are no clear defining characteristics except for the common denominators that are identified as a sense of isolation and a lack of social integration leading, in turn, to an erosion of self-esteem and self-worth among many of the shooters. In some instances, they feel unfairly treated by others and are not satisfied with the way in which they lead their lives. This outlook can lead to depression, and in many instances, instead of the anger being focused inward it is focused outward toward others. But because there is no clearly defined profile, school shooters are also thought to be intelligent, capable, social, and likable people who do not fit the stereotype. Many school shooters, however, did have prior experiences with bullying and aggression. Much of the bullying centered on the shooters' masculinity, which leads to the one common factor among almost all shooters: gender. White boys are the shooters. Why boys and not girls seems to stem from the intractable gender difference around violence. Boys see violence as a legitimate way to resolve conflicts and its actual use. Girls often lose their voice when confronted with trauma or violence, where boys can gain a voice around false bravado, risk taking, and gratuitous violence, which some have called the "boy code."

Risk Factors

In September 2000, the Federal Bureau of Investigation compiled a list of risk factors at the conclusion of a two-year study of school shootings. Traits they identified included poor coping skills, inappropriate humor, alienation, signs of depression, drug and alcohol abuse, narcissism, access to weapons, and no limits to, or monitoring of, television and Internet use by the shooters. In the same report there is a discussion of attending to clues of a student's personality that may come from seeing how a student copes with conflict, disappointments, insults, and other stressors that may occur in the student's life. How they express anger, frustration, and sadness can also be clues. Some predictors of a person who may engage in this violent behavior would be if a student can or can't empathize with others, sees others as inferior, has disdain for others, dehumanizes others, or has an exaggerated sense of entitlement. They may externalize blame, exhibit anger management problems and intolerance, have a lack of trust, and may look to manipulate rather than relate to others.

Three dynamics are identified: the school dynamics, the social dynamics, and the family dynamics. Professionals need to pay close attention to schools and students to search for clues to how the environment can help create a culture that breeds this type of violence. There is no one indicator that will appropriately identify or profile a shooter, but they can be identified if there are professionals who are attending to the whole person, including their family history and the school environment of the students with which they work.

School dynamics play an important part of the equation in determining why a shooting would happen on the campus. Factors that have contributed to creating a culture where this kind of violence occurs include a tolerance for bullying. Officials may be oblivious to it or intervene only selectively. The school may promote or maintain inequitable class or race divisions. There is often a "code of silence" among students with little trust of the adults in the community.

After the Columbine High School shooting that occurred in Littleton, Colorado, in 1999, schools around the world began to address what became known as the serious issues of bullying and aggression in high schools and universities. What educators now recognize is that there are long-term effects that result from bullying, including anxiety, depression, and suicidal ideations. In order for violence to come out of these experiences, there has to be a target and motive for violence, a way to commit the violent act and a means to do it. In contemporary society, violence is expressed as a form of entertainment that is glorified in almost every type of media children experience. Such experiences can lead to a condition of desensitization of the effects of actual violence and hate, and distort the perceptions of shooters. Violence is believed to be a learned behavior, and coupled with relatively easy access to firearms, violence becomes deadly. These factors brought together can lead to a school shooting.

In the case of some school shooters, a pre-existing mental disorder may operate as the stimulus for the acts of violence. In the case of Eric Harris, one of the Columbine shooters, he was found to be a psychopath. Psychopaths are aware of what they are doing but have the capacity to rationalize their actions. They have no conscience, view themselves as superior to others, and lack empathy or remorse for their behavior.

Impact of School Shootings

A political effect has evolved as a result of school shootings. That is, many people are demanding clearer and stronger gun control laws. There are many who are opposed to stricter gun control laws. People believe that if students could carry concealed weapons they might be able to stop a shooting incident either from occurring at all or at least minimize the loss of human life. Fear of school shootings is a consideration of school officials from the elementary institution to college and university campuses around the world. There has been a call for a comprehensive violence prevention plan where there is an informed judgment on assessing threats within a school without overreacting and unfairly stigmatizing or punishing those who are not dangerous.

After the Columbine High School and the Virginia Tech University shootings, schools have begun to address the issues of bullying and violence on school campuses by adopting and implementing peer mediation and counseling services alongside antibullying campaigns. There are metal detectors

and resource officers at many schools and teacher training on how to attend to the clues previously mentioned. Communication systems and emergency response procedures have been improved. Teachers and administrators are being trained as first responders in the event of a shooting to keep students safe or care for injured students. Technology is being embraced and a new system called Rave will alert students by text messages on their phones to warn them of danger. Threat assessment teams are being used on high school and college campuses. This team is a multidisciplinary unit that determines an appropriate response to a threatening statement or writing. The idea is how to help the individual by identifying the available resources. On college campuses there is a more stringent screening process for students.

The Future

Many suggestions are proffered on how to prevent school shooting in the future, including a proposal to permit teachers and administrators to have access to firearms. Another proposed solution is to train students to respond in a school shooting situation. In this form of training, students would learn how to immediately react to an assailant with any item that is available. But this is based on the assumption that if enough students responded, they would be able to overwhelm and subdue a gunman. Another issue that people believe should be legislated is making it a crime for a child to have unsupervised access to guns and, if a person buys a gun, they should take reasonable precautions to store firearms away from children.

One unintended consequence of school shootings and the social stereotypes that have emerged from these events is the long-term affect of fear and mistrust of people who are different and who might fit the stereotype of a school shooter. This consequence has generated a focus on teaching tolerance and conflict resolution to help ameliorate the conditions that may lead someone to experience a sense of hopelessness and disenfranchisement as a result of their school experiences.

School shootings have changed the culture we live in because these events are thought to represent a common occurrence. Although this fear is prevalent and contrary to the myths that have evolved from those school shootings that have occurred, school shootings are actually quite rare. Despite this social fact, in the years following the Columbine High School shootings, there has been an incredible amount of research conducted and books written in which the analysts attempt to identify what can be done to reduce the possibilities that such events will happen again. There is a concerted effort by school communities to pay close attention to the people in those communities and hopefully identify and provide support to the individuals who need it.

Edie Marie Lanphar

See also Adolescence and Death; Depictions of Death in Television and the Movies; Hate Crimes and Death Threats; Massacres; Video Games

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Second Burial

Second burial terminates the cycle of mortuary rites that follow first burial. Between the first and the second burials, there is an intermediary period that coincides with the duration of decomposition of the corpse. After exhumation, the bones are collected, sorted, and ritually cleansed, and then moved to a

new location. This can either be an individual grave, a common grave, or an ossuary. There is great cross-cultural variability in the traditions of second burial. Examples of second burial can be found in Asia (e.g., Kalimantan, China, Japan, Taiwan), Africa (e.g., Mali and Madagascar), Australia, and in Europe (e.g., Greece, France, Austria, Switzerland, the Netherlands). Second burial does not necessarily involve exhumation. Second mortuary rites can also be performed with a substitute for the body, but the body typically accompanies the relocation of the site of worship or honoring of the dead. In most cases, the second burial is considered final, but tertiary burials do occur. When the second burial specifically entails the removal and reburial of the corpse, it is called the secondary burial. Next to secondary burial, other forms of secondary disposal exist, as the body can also be cremated or displayed after an initial period of burial.

Research on Second Burial and Its History

Robert Hertz was the first scholar who investigated secondary rites of disposal. In 1907, he described the secondary treatment of human remains by the Dayak in Borneo and keenly observed the regular and socially sanctioned relocation of relics of some or all of the deceased from a temporary to a permanent grave. Hertz's analysis of the second burial drew attention to mortuary rites as indicating a transition rather than a termination. Hertz argued that, among the Dayak, the body cannot immediately be taken to its final resting place; instead, this transition can only be made after an intermediary period, during which the body is placed in a temporary shelter. Across different cultures, depending on the method of disposal, the intermediary period varies from 40 days to 15 years—lasting minimally until the bones have become dry. Especially important in this process are notions of impurity, pollution, and purification. The soul of the deceased is feared by the living because, until complete decomposition of the corpse, a soul is considered to remain on earth and capable of inflicting harm upon the living.

Parallel to the transformation of the decaying corpse, the soul of the deceased must pass through a liminal phase before receiving its final destination. The Dayak believe that only after the second burial will the soul enter the land of the dead. Hertz's analysis of the second burial demonstrates how the fate of the corpse and the soul are interlinked. Furthermore, it shows the impact of the death on the deceased's social environment. After the death, the intermediary period provides the mourners with the time needed to come to terms with personal loss. Like the dead, the living undergo a liminal phase, during which their identity is adjusted. Through enacting the final passage, not only is the soul transferred to the land of the dead, but the rites of the second burial also restore the "normal" social fabric among the living.

Thus, second burial concerns both the transitional status of the living and the dead; it is a passage in which the living, the soul, and the body progress from one state into another. The second burial is best understood as part of a series of accumulative death rites that take the living through various mourning phases according to the way they perceive the condition of the deceased.

Finally, critics of Hertz claim that the timing in second burial is also related to economic factors. They argue that the intermediary period is also needed to collect money and materials for the second burial, and that secondary burial rites vary along with social status. Notwithstanding the critics, Hertz's account of secondary burial rites provided us with an instrument to analyze mortuary rites as part of a tripartite process in which the corpse, the soul, and the mourners are interlinked.

Second Burials in Asia

Typical examples of secondary burial are seen in the southern provinces of China (e.g., Fukien, Kwangtung, Hong Kong, Taiwan). During the initial stage, the deceased is buried in a coffin at a temporary grave. Secondary burial takes place after 7 to 10 years. The coffin is exhumed and the bones are collected in a ceramic pot and finally reburied in a permanent tomb alongside their collective ancestors. Chinese secondary burial is based on the concept of yin and yang. For the Chinese, flesh is inherited from the mother and is yin, in essence, while bones are passed on from the father and are yang, in essence. The bones are retained and worshiped, as they are considered pure, whereas the flesh, which is impure, is the source of death pollution and must be completely removed by decomposition. The preservation of bones is

paramount in maintaining the realm of the ancestors as the continuation of the pure male line.

Second burials were common in the southern part of Japan. Japanese folklorists analyze these second burials as part of a "double-grave system" (*ryōbosei*) in which the burial grave and the ceremonial grave are separated. Japanese second burials are different from Chinese secondary burials; they do not include the exhumation and reburial of the dead at the second burial site. In Japanese second burials, the corpse is permanently interred at a collective community burial site, while the ceremonial grave is a monument honoring the household's collective ancestors. After 49 days, when the period of mourning ends, the bereaved no longer visit the burial site, but instead utilize the household ceremonial site for ancestor worship. Japanese folklorists have debated its historical origins and the reasons behind the double-grave system, but have not reached a consensus. They are in agreement, however, that second burial links Japanese perception of the afterlife, purity, and pollution. The ceremonial grave ensures the transformation of the deceased into a purified ancestral spirit and an agricultural deity, who in turn blesses the household and its community. This is central to the well-being of the household and community. After World War II, the practice gradually ceased due to modernization, urbanization, and the commercialization of death rituals, and was replaced by the practice of a single grave as in the rest of Japan.

Second Burials in Europe

In secondary burial rites in Greece, women have an important role in burying, exhuming, and reburying the dead. After three to seven years, the bones are exhumed, formally putting an end to the period of mourning. After a priest's blessing, the deceased is exhumed by the next of kin. The bones are carefully collected, washed, rinsed with vinegar or Greek wine, and left to dry in the sun. Thereafter, the bones are carefully sorted and gathered in a box in which the skull is placed on top. By segregating the wet remains of the flesh from the dry, purified bones, the corpse is ritually transformed and the deceased's passage into the otherworld is facilitated. It is believed that the bones of a sinful person will be covered with hair and flesh. Only if the bones are clean and white at exhumation has the soul completed its journey. Finally, the bone box is placed in the local ossuary. However, this does not necessarily mean that the deceased is depersonalized, because the family continues to care for the bone boxes of their relatives in the ossuary by bringing flowers, candles, or photographs.

Secondary treatment of human remains is also common in other parts of Europe. Even though second burial is mostly mentioned in the case of repatriation of war dead or alongside examples of famous people, such as Ludwig von Beethoven, up until the 19th century, second burial took place throughout Europe. In countries including Austria, England, France, Germany, Italy, and Switzerland, bones and skulls were exhumed and received a second burial in an ossuary. In Hallstatt, Austria, the oldest bones in the churchyard were exhumed every 10 or 15 years. After that the skulls were cleaned, bleached, and painted by the bereaved. Some survivors painted a cross, a flower, the deceased's name, and sometimes even inscribed the cause of death on the skull. This tradition is only infrequently practiced today.

In the Netherlands, a new death rite is emerging after the funeral that was previously considered the final death rite. Since the early 1990s, ashes are increasingly taken home after cremation and sometimes processed in mourning relics, creating a longer prolonged period of ritualization. While the positioning of the ashes used to be in the hands of crematory personnel, more commonly nowadays, next of kin scatter or place the ashes themselves while reading out a poem or placing flowers.

The same accounts for burials. In the Netherlands, grave rights are bought for approximately 10 to 20 years, ensuring full decomposition of the corpse. Thereafter, the next of kin can either prolong or relinquish these rights or as a third choice, opt for second burial, executed by professional gravediggers. Secondary disposal occurs for three main reasons: first, to reunite deceased family members that are buried separately; second, to reduce travel after the bereaved move; and finally, to revise the choice of burial and opt for secondary cremation instead.

Generally, in second burial the corpse is ritually purified from death pollution through separating the flesh from the bones. The transformation of the corpse corresponds with a passage of the

deceased into the realm of the dead. While the mourners re-encounter the dead and give the transformed corpse a new place to rest, the relationship between the living and the dead is reconfigured into one of harmony. In contrast with these examples, the new practice of secondary burial in the Netherlands is not so much about the transformation of the corpse and transition of the soul as about changes in the living situation of the bereaved affecting the arrangement of the deceased.

Meike Heessels and Hikaru Suzuki

See also Ancestor Veneration, Japanese; Body Disposition; Exhumation; Mortuary Rites

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Serial Murder

Beginning in the 1880s and for the next 100 years, the phenomenon of multiple murders attributed to one individual was referred to as "lust murder," and, although the term "serial murder" was first coined in the latter half of the 20th century, the media confused serial murder with mass murder, referring to the latter term until the end of the 1980s. As more instances of sequential homicide were officially recorded throughout the first half of the 20th century, informed explanations of serial murder were developed during the 1960s and 1970s by government analysts interested in the nature of such "multicide." By the 1980s, scholarly literature also had been developed. Much of this research was conducted in Australia, Great Britain, Germany, and the United States and is complemented by the FBI Supplementary Homicide Reports (SHR), which provides an incidence-based compilation of homicide victims and offender sociodemographic data.

Accordingly, six kinds of murders are identified, namely: single, double, triple, mass, spree, and serial. The multiple-homicide concept includes two of these six classifications, serial murder and mass murder, thereby providing an important operational distinction. Articulated by James Alan Fox and Jack Levin, the multiple-homicide concept is defined as the murder of at least four victims. By establishing this minimum body count, multiple killing is distinguished from homicide generally. This conceptualization further differentiates the forms of multiple homicide, namely, those cases in which victims are slain at once (the mass murderer), over a short period of time (the spree killer), or over an extended period of time, which distinguishes the serial murderer concept.

Defining Serial Murder

The FBI's *Crime Classification Manual* provides a concise, albeit controversial, definition of serial murder as, "Three of more separate events in

three or more separate locations with an emotional cooling-off period between homicides." Thus, several definitions of serial murder have been advanced. Among these are those events we now refer to as serial murders but were once identified as "stranger murders." This phenomenon was also referred to as chain murder, mass murder, and, later, multicide. Introduced into the literature in 1972, the term *multicide* characterized an act by an individual with a psychopathological personality who committed a number of murders over an extended period of time.

Even the origination of the term *serial murder* is itself in dispute. Once thought to be used for the first time in 1982 by an FBI agent, there is evidence that the term was actually created in 1966 by the British author John Brophy in a book titled *The Meaning of Murder.* The term *serial murder* is again found in the literature based on the work of forensic psychiatrist Donald Lunde, whose book, *Murder and Madness,* was published in 1976.

Although serial murder varies widely by geography, countries such as Australia, Germany, and Great Britain rarely record serial killing events. It is estimated that 80% of all known serial murderers identified during the 20th century resided within the North American continent, especially in the United States. Despite the claim, serial murder is not a new crime wave that began in the 1960s. Placing the available data within an appropriate social and historical context offers the insight that within the United States, the multiple killings were at least as prevalent during the1920s and 1930s as they have been since 1965.

During the 100-year period from 1900 to 1999, there were 1,246 serial killers officially documented worldwide and, despite these estimates, only 236 are known to have resided within the United States. Of the estimated 18,361 murder victims worldwide, a total of 3,313 were murdered in the United States. During the period from 1920 to 1940, Germany reported a dozen cases of serial killing in which over 20 victims were claimed for each case. Given that this kind of serial murderer activity was not documented in that country prior to or since that time period leads to speculation as whether the cause of this high number of deaths may be attributed to politically motivated murder.

In Australia, 5% of all homicide events involve multiple victims, but, on average, only 1 multiple homicide is recorded annually. England and Wales record few cases of serial murder. For the period of 1940 to 1985, only 12 cases were recorded in England, with a victim count that ranges from 4 to 26. For the 46-year period, these 12 cases accounted for a known total of 107 murders; prostitutes (n = 24) represented the largest group of victims.

Serial killers are generally young and engage in a childhood pattern of violence that is directed toward animals and other humans, young and old alike. Approximately 26% commit their first murder while still in their teens, 44% began to kill when in their 20s, another 24% do so in their 30s, and about 4% in their 40s.

Approximately 13% of known serial killings committed within the United States involve multiple killers. Of this total, 56% involve 2 killers, especially 2 females, with the remaining 44% involving groups that vary in size from 3 killers to cults with many members. A variety of pairings are involved among multiple killers, but the most usual grouping involves all females ranging in size from two to a large number of females as characterized by the "angel makers" of Nagyrev, Hungary, who, during the 1920s, murdered their husbands, and the "angels of death" medical murders committed during the 1980s by female personnel at the Lainz General Hospital in Vienna, Austria.

But serial killers are more commonly white males between the ages of 25 and 35 who kill white females. The murder usually occurs in areas of high transience and population change, involves people of similar status, and usually involves the killing of a total stranger, including prostitutes, drug addicts, homeless people, and teenage runaways—people on the fringe of society who hold little community status or attachment.

Historical Relevance of the Serial Murder Concept

Serial murder can be traced to ancient Rome and attributed to Locusta, a female who poisoned her victims. Locusta was executed for her crimes in Rome during 69 C.E.

Throughout the Middle Ages, examples of both male and female serial murderers are noted, including cases involving the bizarre, perverted sex and magic rituals, and other sadistic behavior in which the lives of perhaps 100 children were taken by the

French baron Gilles de Rais. Identified as exhibiting an unhealthy appetite for young children, the Baron was executed in 1440, as were several servants who had procured the unwitting young for the baron's sadistic pleasure.

From the Middle Ages and until the latter portion of the past millennium, poison was the killers' method of choice. And during this period, women were often counted among the worst of the serial killers. Notable examples include a number of females known to have poisoned upwards of 600 people. Some killings involved cannibalism, as children were murdered and then fed to starving family members.

Torture and killing for pleasure well served the needs of Erzebet Bathory, a Hungarian born in 1560. Of noble heritage, her family members included many high-ranking government and church officials. This young serial killer began inflicting torture during her late teenage years upon even younger servants and later village peasants. Tried in 1611 for an alleged 80 murders, it is estimated that Erzebet tortured and killed 300 to 650 victims.

Such examples became more bountiful as the Industrial Revolution took effect, and over time the profile of serial killers also changed. While during the Middle Ages aristocrats preyed upon the peasant class to satisfy their depravity, during the Industrial Revolution members of an expanding middle class killed street prostitutes and homeless children, as well as household employees. In contemporary society, serial murderers are generally from the blue-collar working and lower-middle strata.

Serial Murder: An Emerging Concept

Until multiple homicide was defined in contrast to homicide in general, many deaths that could be attributed to serial murderers were not officially documented. Outside of the church recording of births, marriages, and death, the recording procedures of the Middle Ages were not well orchestrated. Such organization was finally established under the directives of the "moral statisticians" during the early 1800s. One general area of interest for these moralistic but scientifically oriented individuals was crime. Thus, as the process of recording important events became an official government act, more specific information regarding episodes involving suspected serial killings began to emerge.

While official data pertaining to historical serial killing remain sparse, the opposite is now true. In the United States, more than 50 individuals are known to have taken the lives of from 5 to more than 100 victims between the early 1900s to the end of the 20th century. The number of the victims in the United States alone is estimated to be between 3,500 to 6,000 victims annually. In contrast, in the period 1960 to the late 1990s, Australia recorded only nine serial killers. In England, during the 1940 to 1985 period, a total of 12 such cases were recorded.

Many serial killers remain unidentified, and their legacy has grown to the status of urban legends. Classic examples include the Jack the Ripper killings in several districts of London, England, that occurred during the year 1888 and the Axeman of New Orleans, who was thought to have been operating in that city during the 1918 to 1919 period. Then there is the Zodiac killer, who stalked victims in the northern California area during the 1970s and 1980s.

The first known American serial murderer can be traced to the 1880s, when Herman Webster Mudgett killed 27 women. Many of America's most famous serial killers (e.g., William Bonner a.k.a. Billy the Kid) also have been the most prolific, but the scope of their criminality became lost in time as their names and actions merged to become part of the legend of settling the U.S. Western frontier. But this was to change beginning with the 1950s and lasting through the final half of the 20th century. During this period, many more serial killers were identified, including Austria's international murderer Jack Underberger.

The early portion of the modern era produced few documented instances of serial killing, but these became high-profile events. During the first 4 decades of the 20th century, serial murderers received great public attention and their reputation was enhanced in part by the descriptors employed by the media. Terms such as blue beard, black widow, strangle psycho, viciously depraved, mad butcher, backpacker serial killer, lonely hearts killer, torso killer, cannibalistic pedophile, the gorilla killer, and homicidal burglar have all been used to describe both the known and unknown serial killers of this period. During the 1920s, two serial killers of note emerged, namely Earle Leonard Nelson and Carl Panzram, while the decades of the

1930s and 1940s produced Albert Fish, Jack Bird (who confessed to a dozen murders), and William Heirens.

Although females do not receive much recognition, a large portion of the serial murder population is female. For the period of 1800 to 1986, it is reported that of the serial killers identified, approximately 14% were female. Recent critical analysis of the sudden infant death syndrome (SIDS) phenomenon also suggests that many cases of SIDS may cover for the serial murder of infants committed by the mother, either because of the insurance profit motive or because of some unusual urge or compulsion.

Sexual Predation

Of the limited number of research case studies that have been conducted, the sexual homicide type receives the most attention; two-thirds of the serial killers are sexually motivated toward involvement with their victims. It is also noteworthy that the majority of serial killers were not or are not homosexual but, of those who were, many can be counted among the most prolific serial killers.

Analysts of multiple murder pose that while the motivation and patterns of serial killers differ, the most prominent form of serial killing is the power-hungry sadist, who seeks to gratify their sexual fantasies. More than objects of sexual attraction, serial killers view their victims as aesthetically pleasing and a source of companionship. Even when dead, the perpetrator may engage the victim in various forms of abnormal activity, including the use of photographs or recordings, pornography, and engaging in acts of rape, torture, sadomasochism, voyeurism, and lust murder or sadistic brutality, including the mutilation of body parts, especially the genitalia.

Types and Motives of Serial Murderer

There are three types of serial murderers. Nomadic killers move from city to city and state to state. The most common, territorial killers, stalk their victims within certain areas. Currently insights are being brought to bear on the stationary serial murderer, an emergent type of killer who is far removed from the violence and death of the streets and private residences perpetrated by the nomadic or territorial serial killer types. The rarest form of serial murder, the stationary killer, is employed within professional workplace settings that are arenas of public trust, such as hospitals, nursing homes, or rest homes, as well as transient and permanent residential locations.

Also committed in a workplace setting, medical murders, dubbed "mercy killings," committed by physicians, nurses and their aides, hospital orderlies, and dentists, have produced the supposed "hero type" perpetrator. Having created a life-threatening situation, the hero then attempts to save the patient. These kinds of multiple homicides also include the motive of profit (insurance claim) and the sexual motive, such as medicating and then sexually molesting patients. Other workplace killings perpetrated by employees take place in motels and apartments.

Other efforts to classify types of serial killers led to the development of (a) the visionary serial killer (responds to voices or visions that demand certain people be destroyed), (b) the mission-oriented serial killer (destroy evil people because they debase society), (c) the power/control-oriented serial killer (derives satisfaction from having the power to determine the fate of the victim, including sexual arousal), and (d) the hedonistic serial killer. The hedonistic serial murder category is a composite of two subtypes, namely the hedonist, oriented toward pleasure and/or thrill seeking, and the lust killer, who is sexually aroused. Described as a sociopath whose ultimate goals include power and sexual satisfaction, the lust killer seeks to ravage the victim and may even derive more pleasure through postmortem sexual activity.

As noted in the FBI *Crime Classification Manual,* 4 general motive categories include 32 subcategories, each of which can be applied to one or more cases of serial murder. The general categories of motives for serial murder are criminal-enterprise homicide (with 10 subheadings listed), personal-cause homicide (with 11 subheadings), sexual homicide (two-thirds of serial murders are related to this form), and group-case homicide (the 3 subtypes are cult, extremist, and group-excitement murder).

Serial Killers and the General Population

Evidence that psychiatric disorders are more prevalent among serial murderers than the general U.S. population is not strong. In Europe, however,

where serial killing is much less frequent than in the United States, serial murderers are diagnosed as mentally disturbed. What may prove useful to our understanding of whatever differences do exist is based on the hypothesis that most normal people are usually capable of controlling or channeling their aggressive impulses outward toward objects other than humans and animals.

The more common characteristics identified in the international research literature include growing up in a dysfunctional household, a history of poverty and unemployment, a pattern of heavy drinking, a preoccupation with fantasy and murder, and learning to associate violence with pleasure. That these characteristics eventually may lead to the emergence of a serial killer depends on whether such individuals are influenced by higher than normal instigation to aggression and lower than normal inhibitions against aggression that are characteristic of the psychopath and sociopath.

And there is a growing literature that depicts serial murderers as primary psychopaths, secondary psychopaths, overcontrolled (excessive oversight) and undercontrolled (a lack of supervision and guidance), paranoid schizophrenics, and pathologic sexual sadists with histories of childhood physical and mental abuse. Recent findings suggest that 10% of male serial killers may be paranoid schizophrenics, while biological findings indicate brain damage to the prefrontal cortex region may explain some cases. To further enhance this position, some cases of delusional psychotic and paranoid schizophrenics with multiple personality disorder have been cited. Despite these strong characterizations, there does not appear to be sufficient evidence to confirm that the serial murderer is more disturbed or defective, nor do they experience more traumatic childhood life events than are found among the general population.

Dennis L. Peck

See also Angel Makers; Life Insurance; Sudden Infant Death Syndrome (SIDS)

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Sex and Death

An exploration of the contradictory functions of death and sex indicates the existence of several biological dimensions, including the evolution of sex itself, excess mortality of males, reproductive differences that relate to survival, health benefits of sex, and negative health risks associated with sex. In addition, there are cultural elements, such as survival after spousal death, "terror sex" as a coping mechanism to interpersonal threats, sex after physical death, reproduction after death, and concepts related to sex in the afterlife. Although it is difficult to state with certainty that the relationship between sex and death is causal, casual, or coincidental, Thomas Lynch, a contemporary American funeral director and author, suggests that both sex and death leave you wide-eyed, out of breath, are horizontal mysteries, and both are over before you know it. In the following entry, the intersection, interrelationship, and independence of sex and

death in light of evolving cultural, technical, and biological myths and realities are explored.

Evolution of Sex and Death

In 2006, *The New Scientist* published a list titled "Top 10: Life's Greatest Inventions"; sex and death were ranked 6 and 7 on that list. From a biological perspective, sex requires sacrifice in terms of effort, energy, time, risk of injury, and the risk of not finding a mate. But above all, sexual reproduction requires that an individual reduce their contribution to a subsequent generation by half, compared with those who reproduce by cloning or through asexual means. However, regardless of the evolutionary payoff for sexual reproduction, one outcome is most important, namely, it is only with the evolution of sex that death becomes inevitable. Single-celled organisms that reproduced asexually were essentially immortal because exact copies of themselves survived over time. Death, from this perspective, is necessary because of sex.

In human communities, there is a significant sexual divide to mortality and morbidity. The fact that in developed societies, females outlive males by five years on average has significant demographic, biological, and social consequences. The sex of an individual is the most important demographic factor that predicts early mortality. Males may be greater risk takers, but simple risk taking does not fully explain all the mortality differences between males and females. Also biologically, male fetuses are significantly more likely than female fetuses to experience complications and death. That same trend continues after birth and leads to differential male mortality rates.

Why Can't a Man Be More Like a Women

A study of eunuchs, males who had been castrated before puberty, showed an exception to the general rule of females outliving males and demonstrated that those eunuchs lived a remarkable 12 years longer, on average, than males with intact testes. Male aggressiveness and competition for reproductive success is partially controlled by the production of the hormone testosterone, a hormone that is produced in the testes and is, thereby, greatly reduced in castrated males. Male reproductive success and aggressive behavior come with a significant price: reduced longevity. Menstruating and pregnant females, on the other hand, produce significant increased amounts of the hormone estrogen that acts to protect the female heart against oxidative damage and age-related telomere attrition. This monthly massive increase in the hormone estrogen has been labeled the "jogging female heart" effect and helps explain a lower incidence of cardiovascular disease in females before menopause. The health advantage to females is significant; males have a mortality rate from cardiovascular risks that is five times higher, and their morbidity is three times higher than comparable-aged females.

Reproductive Senescence and Its Impact on Longevity

Females who have a delayed onset of menopause (or the cessation of egg production) live longer than females who undergo earlier menopause. Those who have menopause before the age of 40 are at twice the death risk when compared to females who do not achieve menopause until after the age of 50. Thus, fecundity at advanced ages, at least among females, is associated with more extended life expectancies. Among males, there is no similar dramatic and rapid climatic cessation of reproductive function comparable to menopause. However, male fertility does exhibit significant variation and change, especially with age. While older male gamete production, unlike that of aging females, tends to be continuous regardless of age, somatic deterioration and increased death risk is a major outcome of male hormonal adjustment for those over 40 years of age.

When Sex Is Good and Engaging

An article in *The New England Journal of Medicine* makes clear that many older adults in the United States are continuing to be sexually active. Although there were some gender differences and problems associated with sex and aging, older women expressed lower desire (43%), difficulty with vaginal lubrication (39%), and inability to climax (34%), while older men reported erectile difficulties as their most prevalent issue (37%). The frequency of sex did not decline significantly until

after age 74, despite the existence of the problems outlined. In a different study, it has been suggested that the mortality risk was 50% lower in the group with high orgasmic frequency than in the group with low orgasmic frequency. There is further evidence that people who recently had penile-vaginal intercourse had a more positive blood pressure reactivity than individuals who either had a different type of sexual interaction or masturbated, or those who had no sexual encounters. Also, there is the suggestion that semen or properties that it contains have antidepressant benefits for females. In historical settings, whether it is a reading of the *Kama Sutra* or Daoist writings, the message is that an active sex life translates into a healthier and longer life, at least for males. In a recent study, it has been suggested that the frequency of ejaculation is associated with reduced risks for prostate cancer. Even among middle-age males there is strong evidence that sex has a positive benefit for reduced likelihood of strokes and coronary events.

Examples of Sex in Association With Death

According to some cardiologists, a majority of the cases of sudden death during sexual activity involves individuals who were taking part in extra-pair copulations. This is similar to the Japanese term *Fukojoshi*, meaning "death on the stomach." The French term *Le Petit Mort,* or "Little Death," is the description of a sudden death in the act of having sex, especially among males.

Marriage Is Beneficial for a Reduction of Death Risks

Marriage appears to promote longevity and both unmarried women and men have significantly higher death rates than their married cohorts. Men who never married were twice as likely to die as married men of the same age (up to the age of 65), and the death risk for women who never married is lower than men's, but their death risk does not decline after age 65. However, following the death of a spouse, there can be a significant excess mortality among the surviving partner for the first six months of bereavement. Additionally, there are higher mortality risks for younger and more highly educated males following a spousal death, and bereavement was found to decrease with age. The risk of suicide among widowed men is more than three times higher than for married men; there is no difference in the suicide rates between married and widowed women.

Sex and Terror

In the aftermath of the destruction of the World Trade Center on September 11, 2001, numerous events occurred that directly reflect on the relationship between sex and death. The phrase to describe the human social reaction to the aftermath of death, fear, and destruction and the largely uncritical seeking out of human physical closeness in a time of uncertainty and death is terror sex. The terror sex concept is grounded in terror management theory (TMT). TMT suggests that death reminders lead to a greater desire for contact and intimacy, to greater perceptions of romantic commitment in relationships, to more willingness to initiate social interaction, to lower rejection or judgment standards, and to a more positive evaluation of interpersonal skills. These reactions have also been documented in other traumatic events, such as among people hiding in air raid shelters during the London Blitz and survivors of the Los Angeles earthquake of 1994.

This desire for closeness in times of death and destruction can lead to an increase in risk-taking behavior. In a time of heightened danger, safer sex guidelines may be less meaningful or important. A study of men who had homosexual sex following 9/11 found that there was an increase in smoking, drug and alcohol use, and in unprotected anal intercourse, especially among men who reported losing a friend on 9/11.

These findings are consistent with those reported by Arnold Toynbee, who many decades ago wrote a short article in which he identified nine ways through which people reconcile themselves with death. One of the nine methods of adjusting and adapting to death was investing one's continuity in life by creating future generations through engaging in reproductive sex.

Sex After Death

The lack of companionship, lost potential to reproduce, and a lack of sexual activity are issues in life, and these concerns are projected to continue

after death. The Chinese tradition of "ghost marriages," or the marriage between two dead individuals, has a long tradition in the Middle Kingdom, and it is making a comeback in modern times. In rural China, the practice of ensuring that husbands and wives share a grave is again an active part of funeral rituals, even if the male died before becoming a "groom." If an adult male dies and is unmarried, his relatives may contract for a bride from among unmarried females who also died. But an important distinction exists between freshly buried potential "wives" and those of long-established gravesites. This distinction is focused on "wet" and "dry," the level and extent of decomposition of the flesh. A premium is paid for fresh or "wet" female corpses, as opposed to "dry goods" or long buried bones.

Pregnancy Following Death

The cryopreservation of spermatozoa (and embryos) and invitro fertilization (IVF), along with strong human emotions about immortality and genetic and family continuity, lead to procreating after death using various newly perfected reproductive assistant techniques. In a recent case in Israel, a court ruled that parents could attempt a posthumous pregnancy with their dead son's five-year-old gametes that were extracted in 2002. The family advertised for volunteers who would be willing to be impregnated with their dead son's sperm. Over 200 women volunteered to help, and a 25-year-old woman was selected for an IVF procedure.

Such cases generate a variety of ethical and legal issues, such as the autonomy and "presumed wishes" of the dead, the exploitation of the dead by medicine and science, and the well-being of any offspring. Recent discussion of the ethics of posthumous semen retrieval and subsequent potential pregnancies indicate that sperm retrieval from the dead should not be honored unless there is documented written evidence that this is what the dead person desired.

Another case involving the competing ethical and legal perspectives to posthumous reproduction took place in California. A man deposited sperm in a sperm bank and then committed suicide. In his will he expressed a desire for his girlfriend to use the sperm to conceive his child after his death. The court ruled that individual autonomy and privacy permitted the decedent's desire as expressed in the will.

Sex in the Afterlife

The issue of sex in the afterlife demonstrates some of the differences in various religious traditions. Mark Twain in "Letters From Earth" proclaimed of Christianity that it was difficult to imagine a heaven that left out sexual intercourse, the one pleasurable activity that exists for all humanity. Twain saw such a heaven as an "intolerable bore."

The beliefs of dynastic Egypt, Islam, or other faiths affirm that sex is something that happens in the afterlife. To demonstrate the evolving nature of technology on culture, cemeteries in China sell paper copies of Viagra that can be burned in honor of the deceased male relatives to ensure they experience better sex in the afterlife.

Paul Voninski

See also Autoerotic Asphyxia; Gender and Death; Pornography, Portrayals of Death in; Sexual Homicide; Terror Management Theory

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Sexual Homicide

While a consensus definition of "sexual homicide" is difficult to establish, the individual components are readily understood—"homicide" or death at the hand of another and "sexual" or relating to the act of sex. In combination, the term as used here relates to the overlap of real or implicit act or symbolism linking sexual relations, fantasies, and/or desires with the act of killing another. This can be further partially separated into the purposeful sexual killer and the rapist sexual killer. That the euphoria inherent in climactic intercourse is juxtaposed with the profound grief and shock of sudden death is incongruous. Even more unusual, the study of this crime is perhaps the classification of homicide, which typically does not include sexual homicide as a subcategory. In addition, the sexual element may be effectively concealed or missed by on scene investigators and detectives. Fortunately, the overall incidence is less than 1% of all homicides. This entry addresses issues relating to the victims of sexual homicide and perpetrator profiles and motives. Issues relating to the investigation and research of sexual homicide also are presented.

Characteristics of Sexual Homicide

In general, the victim of sexual homicide is female and the assailant male, with same-race-on-same-race instances the most typical. The demographic data continue to evolve and contra-race attacks, intergender assaults, and even occasional female-on-male crimes are becoming more common. In slightly more than half of the cases, the victim is known to their attacker.

The killer's motivation may range from opportunity to sadism. The seemingly most obvious is the erotophonophile who achieves orgasm coincidental with his victim's death. This may be suggested by the nature of the assault and the extent of the victim's wounds. Often, the victim sustains extensive overkill wounds during the course of more targeted assaults. In the extreme, sex-related homicide, known as lust murder, of which sadism is a significant component, the victim's body also may be mutilated pre- or, more commonly, postmortem. The crime scene tends to vary significantly, depending upon the killer's underlying motivation, represented by two extremes, the organized and disorganized scenes.

Motives for Sexual Homocide

Understanding the motivation that underscores sexual homicide is essential to understanding the crime. As undesired intercourse or rape (real, attempted, or imagined) is integral to sexual homicide, recognizing the driving forces behind the act and hence the type of perpetrator may facilitate the investigation. The difference between rape and sexual homicide is that the assailant-victim interaction varies in the degree of force employed. Rape tends to be part of an overall criminal act. In sexual homicide, a dichotomy exists between the "rape gone bad," ending in an initially unplanned death, and the more disturbing purposeful sexual homicide, where killing tends to be the crime proper. It is important to bear in mind that not all rapists are murderers, but all sexual killers perpetrate homicide.

Types of Rapists

There are four generally accepted broad categories of rapists: power-reassurance/opportunity, power assertive, anger retaliation/danger excitement, and anger excitement/sadistic. The precipitating event and the nature of the sex act determine the category.

The power-reassurance or opportunity rapist is by far the most common, representing more than two-thirds of all rapists. Considered to be the "gentleman" rapist, the perpetrator typically uses intimidation to coerce the victim. An event may start as a burglary; if the killer becomes aroused he may take advantage of the opportunity, believing that "making love" to the victim is his privilege.

The power-assertive rapist represents 25% of all rapists. Believing he is entitled to dominate female "playthings," this individual physically threatens the victim. The motive is sex and control of the victim.

The anger retaliation or danger excitement rapists account for approximately 5% of sexual homicides. These individuals are over-represented in lethal sex-related cases. Violent "women haters," these killers desire to humiliate and physically harm their victims. Hostility toward and degradation of the victim may include defecation and/or urination upon the victim but ejaculation is uncommon.

The least common of all rapists (less than 1%) is the anger excitement or sadistic rapist. This lust killer seeks to harm the victim. Satisfaction is derived from the suffering experienced by the victim. The lust or sexually sadistic killer epitomizes the worst fears associated with this form of homicide. Due to the nature of their desires, these assailants often progress into serial killers. It is estimated that two-thirds of serial killers engage in some form of sexual interplay with the victim, although not all serial killers are sexual killers.

Perpetrator

A purposeful sexual killer (as opposed to the unplanned death during rape) typically shows a progression in behavior, beginning with fantasy and progressing through various paraphilias (such as priapism fetishism, autoeroticism, bondage, sadomasochism, asphyxiaphilia, bestiality, and necrophilia). Eventually, the perpetrator acts out the fantasy by killing. The rapist sexual killer may progress along a similar spectrum, but the paraphilias and sexualization of the act of killing are not nearly as prominent and may not be present at all.

The most common sexual killers direct anger toward women and seek to humiliate (anger retaliation or danger excitement) or totally control (anger excitement or sadistic) their victim. In all instances, the perpetrator is driven by aberrant fantasy in which sex is predominately a mental rather than physical act. In the latter case, the killer thrives on being "god" to their victim—literally controlling whether they live or die.

Sexual killers succeed because they do not appear all that different from the rest of humanity, the major difference being that the purposeful sexual killer is typically a sociopath and without guilt. Their motive for killing is completely internal. The origins of the sex killer are manifold; however, at least three areas are considered significant—psychodynamics (internal conflicts), conditioning (environment/behavior), and internal processing.

The perpetrator is usually a young to middle-age white male, but juvenile offenders have been increasing in numbers, tending to act out their baseline anger during the commission of a crime. One-third of the perpetrators record an IQ level of 120.

Although rare, women can be perpetrators as well as being an accomplice to luring other unsuspecting victims into traps to be raped by others. This subset also appears to be evolving in greater numbers. Likewise, youth gangs may become involved in ritualistic sexual homicides as part of an initiation or other rite of passage within the group.

Misconception

A misconception is that sexual killers, particularly the lust murderer, must be insane because the crime is so outrageous. Although a minority of sex killers (typified by the disorganized subset) are psychotic, in fact most are not, as the severe symptoms inherent with a true break from reality including delusions, hallucinations, disorganized thought, and bizarre behavior would typically render the perpetrator unable to carry out more than a single act without detection and apprehension.

Victim

Victims tend to be unsuspecting, naïve, weak (a child or elder), and/or in the wrong place at the wrong time. Purposeful sexual killers, especially serial sex killers, target a specific type victim (e.g., short, muscular build with medium-length brunette hair). This choice may be based upon fantasy or on the remembrance of a specific individual who may have "offended" the perpetrator. The sociopathic nature of the killer does not allow him to perceive his act of killing as wrong.

The site selection also is important. Typically, the killer will encounter the victim in an isolated area or take them to a remote/secluded location, including within a residence, to act out the fantasy. In the more serious cases, the killer may employ a death chamber to hold the helpless victim.

Rarely, a victim may fall into the Stockholm syndrome and begin to empathize with the perpetrator. In such cases, she may become an unwitting

compliant chronic victim. In other instances, the female may partner with the dominant male to acquire victims for his or their mutual sexual desires; this participant may be either a female or a submissive male partner.

Injuries/Assault

The violence tends to be of a close-contact nature, including strangulation, suffocation, or multiple hand-to-hand wounds. Asphyxial deaths and neck wounding tend to be favored modes of violence. The site of the injuries are important, specifically among those involving sexually significant areas, such as breasts, genitalia, neck, back, and buttocks. A related finding is the presence of overkill, or more injuring than is necessary to accomplish the killing. In older literature, such attacks were commonly attributed to a male homosexual partner. More recently, other categories of assailants have been recognized, including any intimate partner, intoxicated on stimulant drugs, and mentally ill (psychotic/schizophrenic).

Postmortem mutilation, such as mastectomy, vulvectomy, proctectomy, or emasculation of the penis, is intended to arouse the attacker. A common such wound is the incision of the abdomen with or without evisceration of various internal organs, including the internal genitalia. Excessive premortem wounding may represent the intent of the perpetrator to make the victim suffer during the assault. In such instances of torture, there may be isolated/combined bondage, bite marks (to sexually significant areas), repetitive wounds, and electrocution. Although rare, the killer's sexual fantasy may involve anthropophagy, or eating part(s) of the victim in a bizarre bonding-like ritual by which the killer feels more "spiritually connected" with the decedent.

Categories of Sexual Homicide

Four categories of purposeful sexual homicide are recognized, namely: organized, disorganized, mixed, and sadistic. In all instances, a sexual act is the basis for the eventual homicide. This act may be obvious, but the significance of the act, as well as the type of act itself, resides with the perpetrator. Although common, penile penetration is not a requisite function. Foreign body rectovaginal and/or oral insertion may be preferred. Often, there may be no direct evidence of ejaculation—the conventional sex act is not the killer's motive. Symbolism may be important with mutilation and/or display of the victim's body a prominent feature. The sex killer's thrill may come from a desire to shock responders and law enforcement with the brutality of the act.

The organized killer is typically intelligent and plans his actions carefully, taking pains to avoid detection and capture. He tends to be mobile and has transportation and will seek out a victim at a distance from his comfort zone. He is usually verbally adroit and will talk the victim (usually a stranger) into his control. His act is fantasy driven and thus ritual (including sadism) is a significant component of the act. The organized killer often takes souvenirs of the crime to continue the fantasy elements of the act.

The disorganized killer is the converse of the organized. Typically inadequate socially and of below-average intelligence, the perpetrator tends to act impulsively on an existing fantasy without significant planning of the sexual component. The disorganized offender will often depersonalize the victim by obscuring the face in some way. The assault is also often marked by mutilation of the body.

Not all patterns are so neatly distinguished. In many there is some overlap between in the level of organization. When the lines are blurred to the point where separation becomes futile, the killer is designated a mixed type.

Finally, the rarest type is the sadistic sexual killer. His motive is simply to control the victim and make the victim suffer. This killer enjoys the act of killing.

The amount of time the killer spends with the victim's body may suggest his comfort level and degree of personalization of the victim. The killer may also attempt to stage the scene in order to deceive investigators. Trophies may be taken from the victim as a fetish with which the killer remembers and fantasizes about the act. In the reliving of the prior attack, the serial killer idealizes the act and can improve techniques employed to attain his "perfect kill."

J. C. Upshaw Downs

See also Death-Related Crime; Homicide; Serial Murder; Sex and Death

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Shinto Beliefs and Traditions

"Born Shinto, Die Buddhist" aptly sums up the relationship between religion and life cycle in contemporary Japan. In a country where exclusive religious affiliation is the exception, not the rule, a generally accepted division of labor exists between Shinto shrines and Buddhist temples, with the former hosting such life-affirming events as the blessing of infants and small children and the latter handling funerals and other rituals concerning death. There are two main reasons for this split: (1) Buddhist priests in Japan, as elsewhere in Asia, came to dominate the performance of death rites because their faith provided highly articulated explanations of the afterlife and specific procedures to navigate it; and (2) Japanese have long believed that the native deities worshipped at Shinto shrines—beings called *kami,* who take the form of natural objects, human-like gods, or deified humans—abhor the pollution (*kegare*) generated by death. Concern about this pollution defines, in large part, the contemporary relationship between death and Shinto (meaning "the way of the kami"), so a discussion of its historical basis and ritual consequences follows.

Death Pollution and the Imperial Court

The idea that death is polluting extends back into ancient times. A Chinese record dating to the 3rd century notes that the Japanese made a practice of immersing themselves in water after funerals as an act of purification. Concern about the pollution generated by death and measures to combat it also figure prominently in indigenous creation myths, which were not officially compiled and written down by the imperial court until the 8th century, but which had likely circulated in one form or another for many generations.

The most important of these myths concerns Izanagi and Izanami, the male and female kami who together created the islands of Japan. In a stark demonstration of the slippage between mortals and gods characteristic of kami worship, Izanami dies after giving birth to the fire deity and is consigned to Yomi, a gloomy underworld comparable to Hades in Greek mythology. The anguished Izanagi pursues his wife in the futile hope that he can bring her back to the world of the living. Initially welcomed by Izanami on the condition that he not look upon her, Izanagi incurs his dead partner's wrath by lighting a fire and beholding her maggot-ridden, decomposing body. He flees in horror while the shamed Izanami and other denizens of Yomi give chase. Once he escapes into the open, Izanagi stops his pursuers by placing a large boulder in front of the entrance to Yomi, and his estranged wife responds with a curse, heralding the introduction of death into the world of the living. In the wake of his traumatic experience, Izanami declares, "I have been to a most unpleasant land, a horrible, unclean land. Therefore I shall purify myself." He accordingly performs ablutions in a river, giving birth to more kami in the process. Supreme among them is the sun goddess Amaterasu, progenitor of the imperial line.

Amaterasu's self-proclaimed descendants and the courtiers who surrounded them took for granted that all kami shared Izanami's disgust for death, and thus developed elaborate rules to shield the fastidious deities from it. Regulations established in the Heian period (794–1185 C.E.) required those in mourning, or even those who had simply come in contact with the dead, to refrain from serving the kami for at least a month. The court was particularly strict regarding the imperial shrine

at Ise, dedicated to Amaterasu. For most of Japanese history, the worship of deities specific to Japan intertwined with Buddhist teachings and practices—so much so that kami were commonly viewed as the local incarnations of Buddhas and were enshrined in ritual centers that liberally combined indigenous and imported elements. Yet their close involvement with death and its management was one of the main reasons Buddhist clerics were banned entirely from the precincts of the Ise shrine. In fact, anything associated with Buddhism, and by extension death, was barred from Ise, making it a remarkable exception to the prevailing rule of blending the worship of kami and Buddhas.

Death Pollution and Folk Practice

Ordinary Japanese shared in the court's concern to shield kami from death pollution, creating prophylactic traditions that continue to this day. The most explicit of these is the custom of placing a white cloth or piece of paper over the *kamidana,* a miniature household shrine commonly affixed to a wall inside the home, after someone in the family has died. Many Japanese will also refrain from visiting Shinto shrines for up to a year after the death of a close family member.

The desire to shield kami from death pollution has traditionally extended to humans as well. Contemporary Japanese, unlike their distant forbearers, may not immerse themselves in large bodies of water after going to a funeral, but many still toss salt on themselves before reentering their homes. Salt, like water, is considered to be a purifying substance, and a mourning family will make sure that small packets of it—usually provided by the undertaker—are made available to those attending a funeral.

Until relatively recently, Japanese took even stricter measures to deal with death pollution. In certain communities, for example, it was once common for those visiting a house in mourning to wear disposable sandals and sit on specially provided mats. They also refrained from eating anything cooked in the home, as the cooking fire was thought to be contaminated by death. The now largely abandoned custom of bathing and vigorously scrubbing the corpse was another measure related to concerns about death pollution, as was officially sanctioned discrimination against families engaged in occupations, such as burying humans and butchering animals, that brought them in contact with death. Outcaste status was legally abolished in 1872, but discrimination against former outcaste families (now called *burakumin*) persists in some areas of Japan to this day.

Concerns about death pollution have diminished greatly in recent times, but, as the continued provision of salt at funerals shows, they have not vanished entirely. Certain acts associated with death—and thus with misfortune, if not death pollution per se—continue to be taboo in everyday life. For example, Japanese know not to stand chopsticks upright in a bowl of rice unless they plan to offer it to the dead, and also not to pass an item from one set of chopsticks to another, since it is customary after a cremation for family members to lift the bones with large chopsticks, two people at a time, and place them in an urn.

When Shinto took shape as an organized religion in the 19th century (more on that in later text), it incorporated and systematized longstanding folk beliefs concerning pollution and purity. Today, no shrine is complete without its ritual washbasin where visitors pour water over their hands and/or rinse their mouths before approaching the resident kami. And in performing blessings, whether of babies or of new cars, Shinto priests wave a wand crowned with folded white paper in an act of purification called *harai*. Priests are also asked to perform harai at construction sites, which are usually sprinkled with purifying salt and cordoned off with ceremonial ropes. But while Shinto purification rites ward away danger, they do not directly confront death—this in spite of a vaguely defined notion that, after the dead pass out of living memory, they acquire the status of a (hopefully) benevolent ancestor (*sosen*), putting them on par with the kami.

As noted earlier, the ritualization of death falls instead to Buddhism, which has dominated Japanese funerals and memorial services for centuries. When Buddhist teachings took root in ancient Japan, they contributed to prevailing notions about the pollution generated by death and other blood-tainted events, such as menstruation and childbirth. Yet these same teachings, with their emphasis on universal compassion and salvation, also encouraged Buddhist clerics to develop the ritual means to mitigate the danger of death pollution in the present while saving the deceased from

a horrible fate in the future. Offering the hope of salvation, they propagated death practices that have changed in content and meaning over time, but continue to play a prominent role in Japanese funerals and memorial rites today.

Shinto Death Rites: Exceptions to a Buddhist Rule

There are, nonetheless, prominent exceptions to the truism that Shinto celebrates the auspicious occasions of life, while Buddhism handles the ritualization of death. A tiny percentage of Japanese—including, significantly, the imperial family—hold funerals and memorial rites that are explicitly Shinto. Also, it is a Shinto, not Buddhist, institution in Tokyo, the formerly state-supported Yasukuni shrine, that enshrines the heroic spirits (*eirei*) of millions of Japanese who lost their lives in military service to the emperor. The following section, divided into two halves by the Meiji Restoration of 1868, explains the political history that gave rise to Shinto death rites and Yasukuni.

The Politics of Exception: Pre-1868

The practice of revering the deceased as kami, although exceptional, has a long history. Buddhism provided the usual means to explain and manage the afterlife, but if a powerful and angry spirit (*onryô*) caused trouble, enshrining it as a kami was a way to mollify it. The most famous onryô-turned-kami is Sugawara no Michizane, a 9th-century courtier and renowned scholar who ran afoul of powerful figures at court and was therefore banished. After he died in exile, a series of disasters struck the capital. Fearing these to be the result of Sugawara's wrath, the court decided to build him a shrine, subsequently transforming him into the kami Tenjin. Today Tenjin is considered to be a beneficent kami of learning, and the many shrines now devoted to him are frequented by students praying for academic success.

Enshrining the dead as kami was reserved for special cases in medieval Japan, but it set an important example for those who, in the 18th and 19th centuries, embraced an increasingly popular school of thought known as nativism (*kokugaku*). Seeking to link the emperor, his subjects, and kami through purely Japanese forms of worship, nativists condemned Buddhism for supposedly hijacking the kami and corrupting indigenous practices, this in spite of the fact that kami worship had been integrated into a Buddhist frame of reference for well over a thousand years. Determined to expel the foreign, they understandably called for a return to putatively ancient, pre-Buddhist ways. Yet by explaining, revising, and systematizing various teachings and practices associated with kami worship, the backward-looking nativists of early modern Japan in effect invented Shinto as a self-aware "religion" with distinct rituals, institutions, and doctrines (whether concerning death or anything else).

As nativists advocated presumably ancient Shinto in place of "foreign" Buddhism, the ritualization of death presented serious difficulties. For one, most Japanese accepted as a matter of fact that kami recoiled from death and anything associated with it. Also, the ancient court texts central to nativist thought—written in Chinese characters imported, along with Buddhism, Confucianism, and Taoism, from the continent—yielded only fragmentary evidence of indigenous, pre-Buddhist death rites.

Ironically, the promoters of a presumably ancient and uniquely Japanese "way of the kami" dealt with this latter problem, in part, by drawing on Confucian (and therefore Chinese) protocol for managing death. This included inscribing a mortuary tablet with the name of the deceased (in contrast to the Japanese Buddhist custom of providing the dead with a posthumous ordination name), as well as specific procedures for handling the corpse. Nativists also borrowed methods developed by the Yoshida lineage of kami worship. Several centuries earlier, the Kyoto-based Yoshida lineage had already regularized the practice of enshrining the dead as kami, employing purification rituals specific to kami worship to transform dead patriarchs into guardian deities rather than put them on the path to Buddhist salvation.

Shrine priests involved in the nativist movement of the 18th and 19th centuries who sought alternatives to Buddhist death rites tried to affiliate with the Yoshida lineage to adopt its kami-producing death rituals. However, standing in their way was the policy of the Tokugawa shogunate (1600–1868), requiring every family to maintain registration with a Buddhist temple, a blanket rule designed to ensure that Japanese eschewed Christianity and

other teachings considered politically dangerous. Because the government forbade Japanese to sever ties with their family temples except in rare circumstances, the Buddhist clergy wielded considerable power over families—especially over their performance of death rituals. So while some priests in the mid- to late-Tokugawa period were successful in shedding their temple affiliations and adopting Yoshida-style funerals, many were stymied by a Buddhist establishment jealous of its prerogatives.

The Politics of Exception: Post-1868

Circumstances for nativists changed radically after the Meiji Restoration of 1868, a coup d'état led by disgruntled samurai who deposed Japan's last shogun in the name of the venerable but long disempowered imperial house. Numbering among the leaders of the new regime were prominent nativists, who quickly engineered an imperial decree ordering the "separation of kami and Buddhas" (*shinbutsu bunri*), a policy that inspired, if not officially authorized, a radical campaign to "destroy the Buddhas and annihilate Shâkyamuni" (the historical Buddha of northern India; *haibutsu kishaku*). The intensity of anti-Buddhist sentiments and actions varied according to region, but throughout the Japanese islands, Buddhist priests were defrocked, temple bells melted down, and worship centers violently stripped of Buddhist implements and practices. The outright persecution of Buddhism was short lived, but the religion never regained the official standing it enjoyed prior to the Restoration. With Buddhism disestablished, nativist officials elevated Shinto in its place, and they set about creating a system of shrine-based teachings and practices centered on the emperor. Their ultimate goal was to construct a widely accepted Shinto faith that would not merely complement Buddhism but displace it.

As part of this effort, they promoted Shinto funerals in place of Buddhist ones, and starting at the top, quickly orchestrated the imperial household's conversion from Buddhist to Shinto death rites. The harder job was convincing ordinary Japanese to abandon Buddhist death rites in favor of Shinto ones, as most were deeply committed to the Buddhist rituals that had linked one generation to the next for centuries. The government also worried about the administrative consequences of releasing Japanese from Buddhist oversight without providing a new form of supervision in its place.

This is why, in 1872, nativist officials publicized a standard format for Shinto funerals that combined Confucian death practices and admonitions concerning filial piety with principle features of kami worship, including ritual clapping, bowing, and offering of sacred *sakaki* tree branches. Desiring to make Shinto funerals widely available while monitoring their performance, officials also decided in 1872 to order all Shinto priests—now regulated by the government—to officiate the unfamiliar ceremonies. Yet in doing so, they still faced the problem that most Japanese believed coming in contact with death disqualified someone from approaching the kami anywhere from a month to a year. A cleric who honored this belief would find it impossible to participate in death rites on a regular basis and at the same time properly execute his duties as servant of the kami. The government dealt with this ritual problem by devising a blunt solution: it decreed that a simple act of purification (harai) would allow a priest to perform a funeral one day and resume his service to the kami on the next.

But declaring an answer on paper was one thing, winning its acceptance another. Despite the government's decree, for most Japanese, a Shinto funeral remained the ritual equivalent of mixing oil and water, a view shared, in fact, by many of the Shinto priests commanded to perform the new death rites. Priests were also divided over the character of the afterlife and the hierarchy of kami inhabiting it. Some nativists adhered to the not-very-attractive scenario depicted in the myth of Izanagi and Izanami: the dead reside in the gloomy underworld of Yomi, end of story. However, the majority imagined rosier circumstances for the dead—and subsequently engaged in bitter theological disputes about the precise nature of those circumstances and the otherworldly lines of authority that determined them.

These disputes, as well as popular resistance to the more radical elements of the nativist agenda, convinced national officials to withdraw state support for the Shinto funeral campaign in the late 1870s. In 1882, the Home Ministry went so far as to ban high-ranking priests at state-controlled

shrines from performing funerals. Clerics who wished to found independent sects and were free to officiate, but those in charge of Shinto rites at major shrines were cut off from the rough-and-tumble world of grassroots ministry. The prohibition was a key element of the Home Ministry's effort in the 1880s to create a formal distinction between private, sectarian Shinto on the one hand and public, state Shinto on the other. The latter, officials argued, was in fact not a religion but instead a "national teaching" that supposedly transcended the narrow interests and petty squabbles of religious sects, Shinto and otherwise.

The Home Ministry's move took any remaining steam out of the Shinto funeral movement—today very few families perform the anomalous death rites—but the state did not completely distance itself from the ritualization of death. Soon after the Restoration, the new regime founded a shrine in Tokyo to worship soldiers who had died in service to the emperor. Named Yasukuni, or "pacifying the nation," in 1879, the shrine apotheosized increasing numbers of the military dead as Japan battled to expand and defend its growing empire. Today, several million "heroic spirits" are enshrined at Yasukuni. These include Japanese executed as war criminals, so visits to the shrine by politicians regularly generate controversy both in Japan and the rest of East Asia, where bitter memories of Japanese occupation remain strong.

And yet, while the souls of millions of Japanese are collectively enshrined at Yasukuni, their bodily remains are dispersed among battlefields overseas or family graves throughout Japan. It is also worth remembering that the funerals held for these individuals were overwhelmingly Buddhist, as they were and continue to be for Japanese in general. So the ceremonies performed on behalf of the dead at Yasukuni may be prominent, but they remain Shinto exceptions to a Buddhist rule. An attachment to Buddhist traditions and a persisting desire to shield kami from defilement make Shinto a matter of life, not death, in the eyes of most Japanese.

Andrew Bernstein

See also Buddhist Beliefs and Traditions; Confucian Beliefs and Traditions; Deities of Life and Death; Memorials, War; War Deaths

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Sin Eating

Sin eating is an English funerary custom of the 17th century, our knowledge of which rests heavily on the evidence of a single man, the antiquary John Aubrey (1626–1697). In his notes on folk beliefs and customs, *Remaines of Gentilisme and Judaisme,* he wrote:

> In the County of Hereford was an old Custome at funeralls to have poor people, who were to take upon them all the sinnes of the party deceased. One of them I remember lived in a cottage on Rosse high-way. He was a long, leane, lamentable poor raskel. The Manner was that when the Corps was brought out of the house and laid on

> the Biere, a Loaf of bread was brought pout and delivered to the Sinne-eater over the corps, as also a Mazer-bowl of maple full of beer, which he was to drink up, and sixpence in money, in consideration whereof he took upon himself ipso facto all the Sinnes of the Defunct, and freed him (or her) from walking after they were dead.

This custom, says Aubrey, had been kept up even in Puritan times in some places in Herefordshire and Brecon: He believed it had once been done throughout Wales, but in his own time was rare.

In 1714 to 1715, some years after Aubrey's death, another antiquary, John Bagford, wrote in a personal letter that he had read in a "Collection of Curious Observations" by Aubrey (since lost) that sin eating had also been practiced in Shropshire villages near the Welsh border "within the memories of our fathers." An old man would be given a small coin, a crust of bread, and a bowl of ale, after which "he pronounced . . . the ease and rest of the Soul departed, for which he would pawn his own Soul."

Finally, in 1852, a certain Matthew Moggridge claimed that sin eating had existed "within the past twenty years" at one place in Wales, and moreover that a sin-eater was shunned and detested by everyone because he carried all the sins of those for whom he had performed the ritual. How far he should be believed is uncertain.

Victorian folklorists hunted for further evidence. They easily discovered instances of bread and ale, or cakes and wine, or bread and cheese being consumed by mourners around the coffin before it was carried from the house, and/or distributed to the poor—but found nothing more about the human scapegoat, the sin-eater. Two scraps of hearsay evidence were reported from East Anglia by 20th-century folklorists. In 1945, L. F. Newman was told that sometimes in the 19th-century, bread and salt that had been laid on a corpse would be given to some unsuspecting beggar, who thus acquired its sins; fearing this trick, tramps still avoided houses where there had been a recent death. In 1958, Enid Porter reported that she had been told that an old woman who had died in 1906 had heard tell, when she was young, of a woman who had become a sin-eater, presumably in the late 18th or early 19th century. She would eat bread and salt laid on the shroud of the dead, and would be paid 30 pennies, whitewashed to look like silver.

Despite the late Victorian anthropological interpretation of E. S. Hartland, who argued that sin eating was a survival of primitive ritual cannibalism, it is best understood in the context of other funerary customs of the late medieval and Tudor periods. These had been based on Catholic doctrines and practices that were condemned by Protestants at the Reformation; what Aubrey describes, well over a hundred years later, appears to be a confused attempt by post-Reformation generations to go on carrying out Catholic traditions.

The chief element in a Catholic funeral is, of course, the Requiem Mass. Here the priest, and at least some of the mourners, takes Communion while praying that the sins of the dead person will be forgiven. Protestant theology forbids such prayer, which has no place in a funeral service. Yet vague memories of the Requiem surely inspired the custom of mourners eating and drinking beside the coffin, giving it symbolic force and spiritual value. In 1671, a French Catholic, Jorevin de Rochefort, mockingly described how at a funeral in Shrewsbury "there stood upon the coffin a large pot of wine, out of which everyone drank to the health of the deceased, hoping he might surmount the difficulties he had to encounter on his road to Paradise" (cited by Charlotte Burne). In Herefordshire, E. M. Leather heard how, even at the end of the 19th century, one of the guests at a funeral who declined a glass of port was explicitly told by an old farmer, "But you must drink, sir. It is like the Sacrament. It is to kill the sins of my sister."

Another common medieval custom at the funerals of wealthy people had been to distribute food and money to the poor, who in their gratitude would pray for the soul of the deceased. This was done by the coffin or at the graveside. It was based on a passage in the Book of Tobias (or Tobit), which forms part of Greek and Latin Bibles, though omitted from Protestant ones: "Alms deliver the soul from all sin, and from death, and will not suffer the soul to go into darkness. . . . Lay your bread and your wine on the grave of a just man" (Tobias 4:11, 18). To give alms to sin-eaters carried on this tradition, even though its roots in official religion and biblical authority were forgotten.

Jacqueline Simpson

See also Funerals; Funerals and Funeralization in Cross-Cultural Perspective

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Social Class and Death

Tragic events often dramatize how individuals' social class determines where, when, and how they die. Class-based stratification systems—determined by one's location within the hierarchies of economic affluence, social prestige, and bureaucratic authority—are one of the most potent determinants of occupation, lifestyle, beliefs, and social opportunities in capitalist societies.

Two such examples of tragic events exemplify the connection of social class and death. Out of the approximately 1,400 passengers on board the *Titanic* in 1912, 535 survived that fateful April night in the cold waters of the north Atlantic. Survival rates were not an equal opportunity. Among first-class passengers, 36% perished, compared to 61% of second-class passengers and 73% of third-class passengers. The crew fared badly as well, with only 22% surviving.

Ninety-three years later, when Hurricane Katrina pounded and flooded New Orleans, the poor living beneath the waterline, in precincts below sea level, once again perished disproportionately. The evacuation plan was based on people driving out of New Orleans. However, 35% of black households did not have access to a car, compared to 15% of whites. Media images of unattended corpses lying in the streets conjured images of third world ghettos. Within weeks of the 9/11 attacks on the World Trade Center, Americans came to know the names, occupations, and final messages of the victims, many of whom were in upper-middle class professions. In the same time frame, Katrina's poorer victims remained nameless, faceless souls warehoused in morgues.

One of the greatest inequalities of life is how much of it one has. In other words, the rich not only have qualitatively better lives, but quantitatively more as well. In 2005, the income gap between America's haves and have-nots reached levels not seen since before the Great Depression, with the top 300,000 individuals earning more than the bottom 150 million combined. Concurrently, although the overall U.S. death rates have declined substantially in the past few decades, the gap between socioeconomic groups has widened. And it was large to begin with. In 1986, for every 1,000 white males age 25 to 64 with incomes of less than $9,000, there were 16 deaths, 6.7 times more than the 2.4 deaths occurring among their counterparts earning $25,000 or more. Among black males, the rates per 1,000 were 19.5 and 3.6 deaths, respectively, for the lower and higher income groups. These inequalities of ratios of mortality rates more than doubled since 1960.

Such death inequity is not unique to the United States nor to modern times. When Tolstoy's terminally ill high court judge Ivan Ilyich inquired how the peasants die, one inference was their greater familiarity with death. In fact, the very genesis of stratification ideas may have derived from observed differences in the death rates of different social groups. Early Egyptian priests undoubtedly had reinforced beliefs about their special station in life when observing those tending the flooded rice fields, workers crippled and short lived, owing to schistomiasis and other aquatic parasites infecting their bodies. In *Plagues and Peoples,* historian William McNeill hypothesized that the Indian caste system developed as Indian civilization encountered disease as they incorporated the "forest people," resulting in strict separation of groups and taboos against physical contact.

Class-based stratification systems emerged with early industrialization, producing its own set of lethal occupational hazards that disproportionately afflicted those on the lower social rungs. In London in 1830, the average age at death for the gentry

was estimated to be 44 years, dropping to 25 years for tradesmen, clerks, and their families, and only 22 for laborers and their families. A century and a half later, the death rate from amenable causes of New Zealand men from the lowest socioeconomic group was 3.5 times higher than men in the highest socioeconomic group. In 2005, a Scottish boy from the wealthiest Glasgow suburb has a life expectancy of 87.7 years, while one from the city's poorest areas can expect to die at 54. In the United States, male high school dropouts are roughly twice as likely to die of chronic (e.g., heart disease) and communicable diseases and more than three times as likely to die as a result of injury than those with 13 or more years of education.

Causes of Class Differences in Mortality

The causes of such class-based life-expectancy inequalities are life long and numerous. They include poor nutrition, unsanitary life situations, lethal occupations, and lack of medical insurance (the condition of nearly one in six Americans in 2005). Also implicated are differences in lifestyle. However, one study found that while lower-class individuals were more likely to smoke, be obese, consume excessive amounts of alcohol, and engage in less physical activity, these risky behaviors failed to fully explain why those with annual family incomes of less than $10,000 were three times more likely to die than those making $30,000 or more. Also involved were greater life stresses and levels of anger, and decreased self-esteem, senses of control, and social supports.

The inequalities of life and death begin at birth. Class inversely correlates with poor prenatal care and low birth weights, both of which increase infant mortality. A 1991 Centers for Disease Control and Prevention (CDC) study found a 4-pound infant is 4 times as likely to have birth defects as an 8-pound baby; low birth rate infants have a 25% chance of perishing before the age of 1 year. As inequality has increased in the United States, the percentage of newborns of low (less than 5.5 pounds) and very low (3 pounds, 4 ounces) birth weights increased from 1990 to 2005, reaching the highest percentages since the early 1970s. Uninsured children (representing one in nine of all American youth in 2005) are twice as likely to die of their injuries in American hospitals as insured children.

Class correlates with exposures to environmental hazards. Racial minorities and the poor are disproportionately exposed to air and water pollution, asbestos, lead, and hazardous wastes—producing a new dimension of inequality called "ecoracism." They live where others refuse, such as next to toxic factories. In the working-class district of Tlalnepantla, Mexico City, in 1984, 80,000 barrels of gas exploded at a liquefied petroleum gas facility, killing hundreds. Three weeks later, in a similar neighborhood of Bhopal, India, toxic gas leaked from an American-owned insecticide plant, killing thousands. These greater exposures of lower-class individuals to environmental hazards are also symbolic. In 1990, while 20% of all billboards in white Baltimore neighborhoods advertised alcohol and tobacco, in black neighborhoods the percentage was 76%.

The most lethal occupations in the United States—fishing, logging, mining (particularly uranium and coal), truck driving, and construction—are typically working-class jobs. Further contributing to class inequalities are exposures to violence, both sanctioned and unsanctioned. Victimization of unsanctioned violence, specifically homicide, is also greater for the poor and working class. Few class differences in casualty rates occurred during the Vietnam War (the last war fought by draftees); however, with the all-volunteer army, social class once again becomes inversely correlated with the likelihood of being a military casualty.

Class differences in mortality rates remain even when medical access is controlled. The first of the famous Whitehall studies, surveys of the mortality rates of British male civil servants age 20 to 64 between 1967 and 1977, all of whom had access to medical care and none impoverished, found those in the lowest of six grades (i.e., doorkeepers) had a mortality rate three times greater than those in the highest grade (i.e., administrators). When controlling for such cardiovascular risk factors as smoking, obesity, and high blood pressure, the difference in rates was still more than twofold. Studies of subsequent cohorts with focus given to different causes of death (e.g., cardiovascular diseases, diabetes, and cancer) reveal the greater stress of the lower classes to be a potent factor in explaining the difference.

Interestingly, the greater the economic inequality in a given area—whether it be a city, county,

state, or nation—the lower the life expectancy for all social classes. In a study of 282 metropolitan areas, those with high income inequality and low average incomes had 139.8 more deaths per 100,000 than areas with low income inequality and high average incomes. Further, for lower-class individuals, the higher the socioeconomic neighborhoods within which they live, the higher their death rates.

Interactions Among Class, Race, and Ethnicity

In October 2007, the chief of the Department of Justice's voting rights division caused a political firestorm when addressing the National Latino Congresso in Los Angeles. In claiming how Photo ID restrictions at the polling do affect the elderly and how that's a "shame," he added that minorities needn't worry because "minorities don't become elderly the way that white people do. They die first."

Exacerbating the class effects on American mortality rates is the racial factor, producing a double jeopardy. Native Americans age 15 to 24 commit suicide at 3 times the national rate and die in alcohol-related incidents at 17 times the national average. African Americans die earlier than their white counterparts, even when class measures are controlled for. In the United States in 1900, more than 6 in 10 (63%) white females and more than 3 in 10 (32%) nonwhite females could expect to survive to the age of 60. This nearly 2-to-1 ratio is found for males as well; 55% of white males and 28% of nonwhite males survived to age 60.

During the 1985 to 1989 period, life expectancy differences between black and white Americans increased on an annual basis. In fact, owing to the decade's AIDS and homicide epidemics, the life expectancy of black males actually decreased—the only group within developed nations not to experience an increase in life expectancy. In a 1996 study, University of Michigan researchers found that African American females living to age 15 in Harlem had a 65% chance of surviving to age 65, about the same as women in India. Meanwhile, Harlem's African American males had only a 37% chance of surviving to age 65, about the same as men in Angola or the Democratic Republic of Congo.

Given how growing inequalities of the life expectancies of social classes is strongly related to their inequalities of income (with differences being amplified among minorities), the possibility of death in triggering class conflict is always a possibility. Mortality rates have become a form of political box scores, gauging the adequacy of nations' economic development, welfare systems, and institutionalized social justice. In 2007, the United States ranked next to the bottom of 33 industrialized nations in its newborn mortality rate and 42nd of all countries in its citizens' life expectancy (down from 11th position 2 decades earlier).

Class Differences in Mortuary Practices

The inequalities of attention giving in life do not end with death. Cemeteries, for instance, reaffirm the social order of the living, with the most prominent locations and memorials reserved for the elite. Minorities and the poor will have their own final resting places either beneath numbered plaques in some potter's field for the indigent or segregated within a community's common burial site. Obituaries also reaffirm the social registry. The higher the individual's social class, the more likely they will receive an obituary.

England's 1832 Anatomy Act, in an attempt to counter a plague of body snatchings, permitted the dissection of "unclaimed bodies," which invariably would be the poor from workhouses and public hospitals. That poverty would be the grounds for dissection represented the final indignity, a stigma dating back to Henry VIII's edict limiting dissection to hanged murderers and an affront to a Christian population believing that the body must remain intact in order to be reunited with the soul during the Last Judgment.

When those at the lower socioeconomic rungs have financed their funerals, they often pay proportionately more. During Victorian times, the lower classes would bankrupt themselves aping the ceremonies of the elite, perhaps trying to give to family members the dignity never received in life. This period of early industrialization and urbanization was an era of increasing mortality rates, and when wealth, respectability, and salvation were linked, all classes desired a "good" funeral. In the late 20th and early 21st centuries, affluent

Americans were more likely to choose less expensive funerary options, particularly cremation, than those of the working class.

Michael Kearl

See also Cemeteries, Unmarked Graves and Potter's Field; Economic Evaluation of Life; Economic Impact of Death on the Family; Mortality Rates, Global; Mortality Rates, U.S.

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Social Functions of Death, Cross-Cultural Perspectives

Death occurs in all societies, yet it evokes an incredible variety of responses. At the moment of death, survivors in some societies remain rather calm, others cry, and still others mutilate their bodies. Members of some societies officially mourn for months, while others complete the ritual within hours. In many societies, families are involved in preparing the corpse for the funeral ritual; in others, families engage professional funeral directors to handle the job.

The variety of responses to death are noted by Richard Huntington and Peter Metcalf in *Celebrations of Death: The Anthropology of Mortuary Ritual.* Corpses are burned or buried, with or without animal or human sacrifice; they are preserved by smoking, embalming, or pickling; they are eaten—raw, cooked, or rotten; they are ritually exposed as dead or decaying flesh or simply abandoned; or they are dismembered and treated in a variety of these ways. Funerals are times for avoiding people or holding parties, for weeping or laughing, or for fighting or participating in sexual orgies.

Whereas death rituals in the United States are generally subdued and rather gloomy affairs, some societies engage in rather spirited activities. The Bara of Madagascar, for example, engage in "drunken revelry" at a funeral—rum is consumed, sexual activities occur, dancing takes place, and contests involving cattle occur. Among the Cubeo of South America, simulated and actual ritual coitus is part of the mourning ritual. The dances, ritual, dramatic performances, and sexual license have the purpose of transforming grief and anger over a death into joy.

In most non-Western societies, death is not seen as one event, but rather as a process whereby the deceased person is slowly transferred from the land of the living to the land of the dead. The process is illustrated by rituals marking biological death, followed by rituals of mourning, and then by rituals of social death. The deceased person is often viewed as a soul in limbo during rituals of mourning, though he or she is still a partial member of the society.

Understanding Death Rituals

Ritual, defined as a symbolic affirmation of values that are culturally standardized through the expression of utterances and action, is an effective means of reinforcing these important sentiments. Ritual makes death less socially disruptive and less difficult for individuals to bear. Rituals differ from other behaviors in that they are formal, that is,

stylized and repetitive in that these are performed in special places, occur at set times, and include liturgical orders.

Death Rituals as a Rite of Passage

When the social positions people hold in society change, identities change as well. Such transitions in identity require significant transitions in life as well, including the ability to adjust and adapt to these transitions. Human beings construct rituals as one means of acknowledging and adapting to change. Consider the following transitions: a child becomes an adult, a single person commits to another in marriage, a married couple becomes parents, a worker retires, and a person dies. In most societies, each of these transitions is marked by collective actions (or social rituals) that acknowledge a change in identity.

Death is a transition, the last in a series of transitions, or rites of passage. In many cultures and religions, being dead is another status change, replete with a new role and obligations. Often the dead are expected to give advice, cure illness, reward good deeds, and ensure a good harvest. In Ireland, the dead are called upon to cure the afflicted and to comfort the lonely. Thus, in Ireland, people never say farewell at a funeral because they fully expect to be in contact with their friends and loved ones again.

The moment of death is related not only to the process of afterlife, but also to the process of living, aging, and producing progeny. Death relates to life—to the recent life of the deceased and to the lives that he or she has procreated and now leaves behind. There is an eternity that divides the quick from the dead. Life continues generation after generation, and in many societies, it is this continuity that is focused upon and enhanced during the rituals surrounding a death.

Structural-Functional Explanations

The structural-functional perspective views funeral rituals as an equilibrium-producing process. Specific functions of rituals include validating and reinforcing values, providing reassurance and feelings of security in the face of psychological disturbances, reinforcing group ties, aiding status change by acquainting people with their new roles, relieving psychological tensions, and reestablishing patterns of interaction disturbed by crisis.

Similarly, burial rite functions can provide meaning and sanction to the separation of the dead person from the living. Moreover, burial rites help effect the transition of the soul to an otherworldly realm. These rituals also assist in the incorporation of the spirit into its new existence. Finally, death rituals are emphasized to re-create social solidarity and reaffirm social structure. Death disrupts social networks and relationships, and the rituals help restore order.

Reaffirming social structure is often accomplished through the family reunion that occurs as an unintended consequence, or a latent function, of the funeral ritual. The intended consequence, or manifest function, of a funeral is to pay respect to the deceased and to support the survivors. The latent function is to bring family and community together.

Burial ground serves as a symbolic representation of the social order. Among the Merina of central Madagascar, for example, after death one returns "home" to the tomb, representing a regrouping of the dead—a central symbol of the culture and an underlying joy of the second funeral. By the entry of the new corpses into the collective mausoleum, the tomb and the reunited dead within it represent the enduring descent group and the source of blessings and fertility of the future.

In older American cemeteries, family solidarity was preserved in the family plot, where many members of a single family were buried together in a space delineated by fences, headstones, and footstones. Shared tombstones for married couples often declared this family unity and solidarity with the epitaph "Together Forever."

Customs at Death

Most cultures encourage families and friends to become involved in preparing the corpse for its final disposition. There are two death-related cultural perspectives. First, different practices exist that are unique to the culture in which these occur. An alternative viewpoint is that there are common human needs (e.g., to dispose of the body), and each society creates practices, rites, meanings, and rituals that are functional equivalents to those found in other societies.

Rituals Performed Prior to Death

Having a cultural framework prescribing proper behavior at the time of death provides an established order and perhaps gives comfort to the bereaved. These rituals provide the survivors with something to do during the dying process and immediately thereafter, thus facilitating the coping abilities of the bereaved.

It is important in many societies, including the United States, that one is with the dying person at the time of death. A visit before death allows one to say goodbye. Among the Dunsun of northern Borneo, relatives are encouraged to come and witness the death. The dying person is propped up and held from behind. When the body grows cold, the social fact of death is recognized by announcing, "He exists no more" or "Someone has gone far away."

The Ik of Uganda place the dying person in the fetal position because death represents a "celestial rebirth." The Magars of Nepal purify a dying person by providing water that has been touched with gold. The Maori of New Zealand also have a ceremony intended to send the spirit of the dying person away while the person is still alive and conscious of what is happening. After the spirit is gone, the individual may not be biologically dead, but, in a Maori sense, "is dead." Ceremonies then commence and a space is set aside in the meetinghouse for the corpse to lie in an open coffin.

Final Disposition

Rituals and rites related to final disposition serve the functions of maintaining positive relationships with ancestral spirits, reaffirming social solidarity, and restoring group structures broken by death. In many cultures and religions, individuals are considered to be composed of several elements, each of which has a different fate after death. Thus, the actual destruction of the corpse, whether through cremation, burial, or decomposition, is thought to separate the elements—the various bodies and souls. There are two primary forms of final disposition, earth burial and cremation. The dominant religions that practice earth burial are Judaism, Christianity, and Islam, while Buddhism and Hinduism practice cremation. However, in all forms of final disposition, ceremonies declare that the body no longer has any value, but the soul lives on.

Native American burial practices, for example, provide evidence that tribal groups do not abandon their dead; rather, they provide the dead with ceremony in the disposal. Indeed, ceremony and the manner of disposition of the dead go hand in hand with death in different cultures. These disposition rites not only reaffirm group structure, but also enhance social cohesiveness.

In sum, the act of dying has an influence on others because it is a shared experience. This death-related sharing is composed of symbolically meaningful rituals. Because death meanings are socially constructed patterns of behavior, the meanings attributed to dying and death will be determined within the social setting in which they occur. Because death generally disrupts established relationships, cultural scripts aid in providing socially acceptable behavior for the bereaved. Such scripts are essential because these provide social continuity. Burial rituals are important in assuring social cohesion at the time of family dissolution through death.

Family involvement plays an important role in most societies as individuals prepare for death, as they prepare the corpse for final disposition, and as burial rituals that follow are performed. Therefore, whether death rituals involve killing a chicken, scraping the meat from the bones of the corpse, crying quietly, wailing loudly, mutilating one's own body, or burning or burying the corpse, all bereavement behavior has three interconnected characteristics—it is shared, symboled, and situated.

Michael R. Leming and George E. Dickenson

See also After-Death Communication; Communal Bereavement; Communicating With the Dead; Funerals and Funeralization in Cross-Cultural Perspective

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Soul

The various conceptions of the soul include but are not restricted to (a) a first principle or fundamental source of life found in a living thing, (b) a spiritual substance responsible for a thing's being alive and perhaps capable of existing apart from the body after death, and (c) the seat of the psychological operations of a being capable of conscious existence. A given explanation of the soul may be in response to one or more of these conceptions. For example, some have conceived of the soul as a spiritual substance that fits all three of these categories, whereas others have spoken of the soul as a material entity that fits only the first and, perhaps, third categories. In addition to having three notions of soul, further confusion arises because, while some analysts have treated the soul as a physical part of the body, contemporary materialists who believe that something physical exists and fits the first and third categories refrain from speaking of a soul.

This discussion is focused on the conception of soul as a first principle or source of life found in a living thing. A test for what fills the role of the first principle is to inquire as to what is no longer present at the time when what had been a living body ceases to be alive. Three approaches are common.

1. The soul may be taken to be a spatially extended physical object. There has been a common belief in ghosts as spatially extended ethereal beings that depart from the body at death. Alternatively, ancient Greek atomists, such as Democritus, held that the soul is made up of small spherical atoms, and when these depart, bodily death occurs. Plato spoke of a worry that some people had that the soul of one who dies on a windy night might be scattered and dispersed, precluding the possibility of its continued existence after death. If one conceives of the soul as the seat of psychological operations, then one might locate the soul in a part of the body. In the past, the heart was sometimes treated as the seat of emotions; today analysts are inclined to treat the brain as the seat of the emotions, consciousness, and intellect.

2. The soul is held to be a nonphysical spiritual substance that gives life to a living organism. This doctrine, "substance dualism" or "Cartesian dualism," is most closely associated with the philosophers Plato and Descartes. Descartes characterizes the nonphysical nature of the soul in terms of it as being a thinking thing that is not spatially extended—for Descartes, thinking involves any conscious process of which there is immediate awareness. Descartes's narrow conception identified the soul with the mind and held that it is the principle of conscious life. Nonhuman life, Descartes believed, can be fully accounted for mechanistically without appeal to the soul; we only need the soul/mind to explain the existence of a thinking being. It was a notorious feature of Descartes's philosophy that he thought nonhuman animals are altogether lacking in consciousness. It has also been common for substance dualists to hold that a nonhuman animal can possess a nonmaterial soul. Those, not in the Buddhist tradition, who accept the view that reincarnation occurs through a transmigration of the soul appear to be substance dualists.

3. A third approach has its roots in Aristotle's account of the soul. Aristotle held that physical things are a composite of matter and form. A thing is what it is in virtue of its form. Thus, due to a change in form, the same matter may at one time be grape juice, at another time be wine, and yet at a third time be vinegar. Of course, a thing need not retain the same matter to remain in existence; a living thing undergoing metabolism will exchange matter with its environment while remaining the same individual. What makes a living thing alive is that it has a substantial form in virtue of which it is a living thing of a given kind.

Aristotle takes the substantial form of a living thing to be its soul. Thus, for Aristotle, all living things have a soul. This does not entail that all living things have some form of consciousness, but they must have some vital functions to be alive. In virtue of its soul (or form), different grades of living things have different vital capacities. A plant has capacities to grow, take in nourishment, and reproduce in virtue of having a formal organization as a plant. An animal has the previous mentioned capacities plus the capacity to move about and have sensation in virtue of having an animal soul. A human animal also has rational capacities by virtue of its human soul.

Immortality and Personal Identity

Assuming that continued existence of a self or an individual living being requires the continued existence of its soul, there is a close connection between theories of the soul and the question of whether survival of death, or even immortality, is possible. If the soul is not distinct from the body, then it is hard to see how there could be survival of bodily death without a resuscitation or resurrection of the body. Similar considerations apply if the soul is a part of the body: it is easy to see how there could be survival of the death of the soul-part by a resuscitation or resurrection of the soul-part. Once there has been dissolution of the body, it is difficult to see what could count as a resurrection of the same living being. This problem is a special case of what philosophers call the problem of personal identity over time.

Several solutions have been advanced. One proposal holds that the resurrected body will have the same matter that it had when it was previously alive; alternatively, the resurrected body must have the same matter in the same arrangement that it previously had. But a living body's having the same matter and structure as a previously existing living body once had does not guarantee that the same living being is present in both. Imagine that the atoms that made up your body when you were 1 month old—none of which may currently be a part of your body—were reassembled into a configuration they had when you were 1 month old. They would not compose a person who is the same person that once had that body; after all, you are the person who had that body and the person with the recomposed body would not be you. Furthermore, among those who believe in a resurrection, it is commonly held that the resurrected body will not be like the body was when it died; it will not be an identical arrangement of identical atoms. Finally, atoms that constitute the body of one human at its death may be present in other humans when they die. But a belief in a simultaneous resurrection of all humans raises the question of who would get the shared atoms.

Another attempt to solve the problem of identity over time holds that there will be a psychological continuity between the person who dies and the person who is resurrected, and it is this continuity that constitutes personal identity over time. The psychological continuity is typically spelled out in terms of shared memory and similarity of psychological dispositions. A question has been raised whether psychological continuity could be sufficient to constitute the continued existence of the same person over time: it is argued that in theory it is possible for there to be psychological continuity between a person P_1 at one time and distinct people P_2 and P_3 at a later time. Because P_2 and P_3 are distinct from each other and each would have as much a right as the other to be identified with P_1, it follows that neither is the same person as P_1. Thus, the argument concludes, psychological continuity by itself is not sufficient for personal identity.

In the view that the soul is an immaterial spiritual substance, a straightforward solution to the problem of personal identity over time is to hold that continued existence of the soul is sufficient for the continued existence of the person. Because the soul is nonmaterial, the dissolution of the body does not obviously prevent the continued existence of the soul. This view leaves open the possibility of survival of death, with or without a resurrection, and any difficulties previously raised concerning the possibility of a resurrection of the body are mitigated on this account: as long as the soul of a person who died previously is presently associated with the newly formed body, the person with the new body will be the person who died.

Objections raised against Cartesian or substance dualism hold that it is impossible to account for how a nonmaterial soul or mind interacts with the body. It is difficult to see how a naturalistic account could be given of the emergence of an immaterial soul during the evolutionary process. Given that humans lose consciousness when the

living brain is sufficiently disturbed, it may seem that the soul does not have a capacity for consciousness that is independent of the body.

Finally, Aristotle held that if the capacities a being has in virtue of having a soul can only be exercised through bodily parts, then its soul cannot exist apart from the body. He believed that the capacities for reproduction, growth, nourishment, sensitivity, and local motion can have no existence apart from the body. But, he raised the question whether humans have an intellectual capacity that does not depend on a bodily part for its operation and, if so, whether the human soul could have some sort of intellectual existence apart from the body. An affirmative answer was extensively developed in medieval philosophy by Thomas Aquinas and others. It held that the soul can have at least a truncated existence apart from the body in which the intellect and will operate. Aquinas held that only in a bodily resurrection will the human be restored to a fully human life.

James Cain

See also Buddhist Beliefs and Traditions; Christian Beliefs and Traditions; Hindu Beliefs and Traditions; Immortality; Jewish Beliefs and Traditions; Muslim Beliefs and Traditions; Reincarnation; Resurrection

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Spiritualist Movement

The spiritualist movement, centered in the English-speaking parts of North America and in the United Kingdom, is a loosely structured new religious movement (NRM) that emphasizes the immortality of individual spirits, contact with the spirit world through spirit mediums, and spiritual healing. Like spiritualism in the generic sense, found in various forms throughout the world, it denies the finality of death, but it also has many functions depending upon particular social conditions.

Although spirit mediumship is the role of the "spirit medium," and spiritual healing is the role of the "shaman," these two roles overlap in many societies. Both mediums and shamans contact the spirit world, the former for information, and the latter to harness the healing power of spirits.

Mediumistic and Healing Procedures

It is common for both spirit mediums and healers (shamans) to work in an altered state of consciousness, brought on by meditation and/or by prayer. In spiritualist churches today, this altered state is seldom deeper than a light trance, and it rarely involves spirit possession (a spirit taking over the body of the medium or healer). Nevertheless, mediums often say that they have a team of one or more spirit guides (sometimes called "controls") to help bring in messages from other spirits. Also, healers may attribute their healing power to "spirit," which could be anything from a general god-force to particular spirits working through the healer.

Spirit mediums report acquiring information from the spirit world in a variety of ways or "modalities." In one study of 98 American mediums, 70% reported being clairvoyant ("clear-seeing," that is, getting visual images), 61% said they were clairaudient ("clear-hearing," that is, getting voices or other sounds), and 40% thought they were clairsentient or kinesthetic ("clear-feeling" or experiencing body sensations). All of these modalities may be experienced either as realistic sensory inputs or as imagined or dream-like impressions.

Shamans use a great variety of healing procedures in world societies, but spiritualists in particular are trained to do "church healings." These typically consist of brief (5–10 minute) sessions in

which people from the congregation come up to sit on individual benches while the healers place their hands near the sitters' bodies, covering most of the body but with limited touching.

Functions of Mediumship and Healing

Anthropological studies have found a number of functions served by spirit mediumship. In traditional Chinese society, it has been used to discover what the ancestors need in the spirit world. Living relatives then burn "hell banknotes" (imitation paper money made specially for this purpose), or small-scale effigies of cars and houses, or plastic imitations of jewelry for their ancestors, expecting health and wealth from their ancestors in return.

Spirit mediumship has sometimes been used for political purposes, such as in East Africa, particularly Zimbabwe, where the highest status political leaders claimed the aid of the most powerful spirits. The ghost dance movement among Plains Indians (1885–1890) relied upon returning spirit ancestors to protect them against the U.S. military. In ancient Greece, the Oracle at Delphi was consulted for many reasons, including for spiritual advice in political and military affairs.

In the spiritualist movement, however, spirit mediumship has tended to have more of an individual or limited family and friend focus, and less of a focus on the clan or wider society. Spiritualist churches promote the idea that their main purpose is to "prove the continuity of life," or in other words, to convince people that bodily death is not the end of the soul's existence. This may mean alleviating anxiety among individuals about their own eventual deaths, and it may mean consoling people who have lost relatives and friends. Throughout the history of the spiritualist movement there have been revivals of interest in spiritualism during wartime, especially during the Civil War and World War I. Recent books by spirit mediums often emphasize this theme of grief management.

In most traditional non-Western societies this emphasis would seem strange. Chinese, for example, even in modern Hong Kong, have generally taken the spirit world for granted. It may have been feared, but seldom doubted. Westerners who come to have reuniting conversations with their loved ones through Chinese spirit mediums are considered odd. They should be there for practical reasons, finding out what to do for their ancestors, not to manage their personal grief.

Western spiritualist mediums also have norms against forecasting the death of people's relatives and friends. For example, it is acceptable to say, "You really ought to visit your grandmother," but few mediums would say that she is about to die. In fact there is a general taboo against passing on bad news of any kind.

Another function of mediumship stated by spiritualist mediums is that it should "help people." By this they mean that mediumship is a holistic healer, supporting an individual's spiritual, mental, and bodily health. The same claim is made for hands-on church healings.

Messages from the spirit world may relieve anxiety about death and the dead, but they may also contain particular advice about health. In Lily Dale, New York, the largest spiritualist camp, founded in 1878, mediums used to (as late as 1929 at least) give specific medical advice from the spirit world, but this is strictly discouraged today to avoid accusations of practicing medicine without a license. General tips about healthy lifestyles and seeing a doctor, however, are not uncommon in public readings at spirit message services.

Although spiritualist churches discourage or deemphasize it, there is yet another function of spirit mediumship, especially in private readings: fortune telling. If the ideology of spirit mediums emphasizes "proving the continuity of life," the main reason most clients come for private readings is to find out about such things as money, jobs, love life, and personal health. Nevertheless, some sitters (clients) do hope for contact with a particular lost loved one, sometimes expecting, nonetheless, some practical advice from the loved one.

History of the Spiritualist Movement in the United States

As is the case with other NRMs, the origins and organization of the spiritualist movement are complex and diffuse. American spiritualism sprouted from what has been called "the Burned-Over District" in western New York in the early 19th century after the completion of the Erie Canal in 1825. This rapidly developing area allowed for the spread of NRMs like Mormonism and Millerism (Seventh-Day Adventists), and of other movements

like feminism and the abolition of slavery, relatively unchecked by the more established social control systems (including churches) found "back east."

Spiritualist churches now consider their movement to have begun in this Burned-Over District, in Hydesville, New York, near Rochester in 1848. Two sisters, Margaret Fox, age 14, and Kate Fox, age 11, allegedly heard rapping noises in the family cottage. These sounds were interpreted as messages from the spirit world. The family then developed a code, which they claimed yielded a statement from the spirit of a peddler about how he had been murdered in the cottage and buried in the basement.

From this event, Quakers, Universalists, and Swedenborgians spread both the reputation of the Fox sisters and the practices of spirit rapping and table tipping (sitting around a table with one's hands on top, calling on spirits to make it rise or move about). Within several years, these phenomena had spread, especially throughout the United States and England. Margaret Fox confessed to fraud in 1888 but retracted her statement in 1889.

Alongside these spiritual phenomena and practices, a spiritual belief system also developed largely from the writings of Andrew Jackson Davis, born 1826 in Orange County, New York. Davis had a vision in 1844 of the ancient Greek physician Galen and of Emanuel Swedenborg, an 18th-century Swedish scientist and mystical philosopher. After his experience with Galen and Swedenborg, Davis began to perform intuitive diagnoses on patients and to prescribe alternative medical therapies. In 1845, he started lecturing in trance and writing books seemingly beyond his less than one year of formal education.

George Bush, a professor at New York University and the foremost expert on Swedenborg, examined Davis and his ability to dictate in Hebrew, Arabic, and Sanskrit, languages he was apparently unfamiliar with. Bush thought that Davis might be channeling (receiving spirit communications) from Swedenborg. Others thought that Davis might be plagiarizing the works of Swedenborg. Davis's books *The Univercoelum* and *Harmonia,* written between 1848 and 1850, just as the Fox sisters craze was spreading, became prominent in the spiritualist movement, helping to establish beliefs about natural law and the world of spirits.

Partly because spiritualism spread rapidly as a craze in the mid-19th century, and partly because spiritualists tended to resist organizing formally into the kind of church structure they opposed in mainstream religion, we know little about many details of the movement and about how serious it was. The claim is sometimes made that by the Civil War in the 1860s, nearly every American family had at least one spiritualist in it. However, many such people may have limited their involvement to table tipping or to séances (circles of people who sat around a table holding hands as a spirit medium tried to bring in spirits). Although some people sat faithfully in such circles an evening a week, for many it may have been no more serious than playing a board game.

More importantly, the spiritualist movement was associated with other radical movements because many early spiritualists were fallen-away Quakers (who thought that Quakers were becoming too organized), liberal Universalists, and a variety of "free-thinkers." Such related movements include the abolition of slavery, temperance and health reform, and women's rights. Spiritualists tended to be all-purpose radicals, too radical, for example, for most feminists. When Susan B. Anthony spoke several times in the 1890s in Lily Dale, the spiritualist camp, she encountered criticism from more moderate feminists.

Although it is debated just how formally organized the spiritualist movement was before the Civil War, it seems clear that there was more emphasis on creating a national church structure in the 1860s and 1870s. In many cultures, women have been able to gain spiritual power by taking the role of spirit medium, and the spiritualist movement provided the same opportunity compared to established churches that had a heavily male-dominated hierarchy. Once spiritualism became more organized, however, women tended to lose some status in the national groups.

Estimates of the numbers of spiritualists at different times in the United States are impossible to verify due to the participation of a high percentage who were never enrolled in churches, the large number of small coalitions and independent churches, and the fact that the U.S. Bureau of the Census is prohibited from collecting data on religion. There may have been millions of spiritualists in the late 19th century (a few percent of the population), probably a significant decline by the 20th century, and under a million at any one time

since 1926 (a fraction of 1%). However, in a sense, the legacy of the spiritualist movement lives on as one of the roots of the new age movement today, and impacts the current audience for spirit mediums on television, in books, at psychic fairs, and at spiritualist camps like Lily Dale. Throughout the history of the movement, many participants, even leaders, have been members of other churches.

Perspectives on the Spiritualist Movement

Although confronting issues of death is a cultural universal, and religions in all societies question the meaning of death, the spiritualist movement in Western society is in an especially problematic position. It is problematic for both scientific and religious reasons in this cultural context. Each of the next four subsections examines the spiritualist movement's orientation to death and to contact with the spirit world from a different perspective.

Spiritual

Spiritualists claim not only that the life of the spirit lives on past the death of the body, but also that it is possible to contact individual spirits after "so-called death." Most organized religions in the United States and in Great Britain either ignore this possibility or consider it impossible or potentially dangerous to seek out spirits this side of heaven (not to mention hell).

Even spiritual/religious traditions closer to spiritualism have been wary of the spiritualist approach. As previously noted, Andrew Jackson Davis borrowed ideas from Swedenborg, but Swedenborg considered spirits potentially unreliable sources of information. Spiritualists also assimilated concepts from Transcendentalists like Thoreau and Emerson, who disapproved of spirit mediumship. Emerson went so far as to call spiritualism "the rat hole of revelation." Later the Theosophical Society, an outgrowth of spiritualism founded by Madame Blavatsky and Henry Steel Olcott, ridiculed spiritualism for contacting lower-level spirits.

All of the criticisms of spiritualist mediumship found in these other traditions resonate with concerns that present-day spiritualist mediums worry about themselves. Some mediums worry about getting spirit messages from bad energies, envision "a white light of protection" around themselves, and pray for "the highest and best" spirits to come through. It is often said that "just because a person goes to the spirit world, that doesn't mean they get any smarter." Some mediums also encourage people to get in touch with higher spirit guides and teachers in order to become more spiritually evolved.

Having been raised in the same skeptical society as other Americans and British, where science has greater legitimacy than mysticism and spirit contact, spiritualist mediums also doubt their own work on scientific grounds. Most mediums look for confirmations, evidence that their spirit messages are valid, and continue to be pleasantly amazed when they think that good evidence has been established. Many prominent mediums, like Davis himself, were skeptics earlier in their lives.

Spiritualist churches state that spiritualism is a science, a philosophy, and a religion. They also emphasize that there are no religious dogmas, even though they do have a statement of principles that allows for individuals to come to their own understanding of the divine through their own experience. Spirit mediumship itself, they say, is a scientific procedure in that it provides evidence for the continuity of life.

Parapsychological

Although the legitimacy of spiritualist claims to be scientific declined by the end of the 19th century due to the professionalization of mainstream science, various scholars (some of them spiritualists themselves) have examined and tested spirit mediums since the mid-19th century. In 1882, the Society for Psychical Research was founded in London, members of which included eight fellows of the Royal Society. A similar organization began in the United States in 1884. Mixed results included the uncovering of fraudulent mediums but also many cases that some researchers considered authentic or unexplained.

Increasingly parapsychologists (students of allegedly paranormal aspects of the mind, including extrasensory perception, or ESP, and mental influence on objects, or psychokinesis, PK) have worked more in laboratory settings, as did J. B. Rhine beginning in the 1930s at Duke University. Studies of spirit mediums in their natural setting have declined. There is a tendency for

parapsychologists to be wary of the "survival hypothesis," the attribution of seemingly accurate statements by spirit mediums to contact with surviving spirits and to suggest instead that any information in the universe might be known by "super-ESP" (ESP with no space or time limits). Nevertheless, laboratory experiments and other scientific studies of spirit mediums continue today.

Scientific Skeptical/Debunking

There is no absolute separation between parapsychological research and scientific debunking, because both can operate from a perspective of scientific skepticism. However, the Committee for Skeptical Inquiry (CSI), formerly the Committee for Scientific Investigation of Claims of the Paranormal, takes the position that there is no credible evidence for spirit mediumship or spiritual healing.

CSI often attempts to demonstrate fraudulent paranormal feats by showing how they can be replicated by trick magicians. Spirit mediums, they say, often use "fishing" questions in their readings until they say something that extracts information from the sitter either verbally or through body language cues. Cooperative sitters may also interpret the medium's statements to make them fit.

Social/Behavioral Scientific

Most of this entry has been written from a social scientific perspective, pointing out the functions of spirit mediumship in various societies, for example. Spirit mediums or "channels" have often provided the ideology for religious movements by claiming to be sources of revelation. The spiritualist movement in particular has focused squarely on the mystery of death and provided one coping mechanism for dealing with death. Although mediumship poses a problem in terms of being accepted by mainstream natural science, social scientists can study its social functions, and psychologists can explore its psychological and neuroscientific aspects.

Charles F. Emmons

See also Confucian Beliefs and Traditions; Daoist Beliefs and Traditions; Ghost Dance; Grief and Bereavement Counseling; Spirituality; Transcending Death

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SPIRITUALITY

Since the early 1980s, the topic of spirituality, considered by some analysts to be a postmodern offspring of religion, has gained ascendancy among social scientists representing academic disciplines such as sociology, psychology, and gerontology, and the counseling, medical, and nursing professions. This interest has been spawned by rapid changes in societal values, disillusionment with traditional religious institutions in meeting individual needs, a drop in public confidence in religion and religious leadership, and a new cohort of baby boomers who have been described as a generation of spiritual seekers. While religion has always served an individual and an institutional function, the institutional component has come to

be seen as a fixed system of ideological beliefs and commitments that have failed to address the personal aspects of the human experience. Spirituality, on the other hand, is commonly regarded as an individual phenomenon, linked to concepts of transcendence, coherence, and purpose in life. In the following sections, social, theoretical, and methodological issues are addressed.

In North America in particular, a polarization of religiousness and spirituality has occurred, with the former often described as public, institutional, formal, authoritarian, and inhibiting expression and the latter as private, individual, subjective, inward, and freeing expression. While acknowledging the importance of religion and religiousness, the focus herein is on the construct of spirituality, the definitional problems and conceptual controversies, the challenges related to the measurement of spirituality, and the link between spirituality, health, and death attitudes.

Definitional Problems and Conceptual Controversies

The difficulty in the definition of spirituality emerges from the English language itself because of a lack of distinctiveness between the concepts "religiosity" and "spirituality." This can easily be compared to the German language, in which the word *geistig* describes the "human spirit" or spirituality, while the word *geistlich* describes "the sacred or the divine" as embodied in the concept of religiosity. The inability to distinguish between terms has contributed to the confusion, inconsistencies, and a diverse set of definitions of spirituality and religiosity. This is true not only in the lay community, but within the scientific community as well.

Historically, the terms *religiousness* and *spirituality* were used interchangeably with no real distinction made between them. *Religiousness* was the preferred term, although definitions were varied and diverse. The most commonly cited definition defined religiousness as adherence to a set of ideological beliefs, rituals, symbols, and practices associated with a particular creed, denomination, or sect. Moreover, religiousness was seen as consisting of two aspects; namely, the intrinsic and extrinsic religiousness. Intrinsic religiousness refers to a personal experience in which the individual searches for the truth (i.e., religious faith) that may be applied to living life fully, while extrinsic religiousness refers to a rule-oriented religious system that seeks external gain from religious experiences, such as fulfilling one's social needs to include social status and social interaction.

With the rise of secularism, multiculturalism, and disillusionment with religious institutions came a shift toward the concept of spirituality. Current definitions of spirituality have ranged widely, depending on one's theoretical or professional perspective. For social scientists, spirituality involves a search for the sacred. Individuals who practice psychotherapy, on the other hand, tend to view spirituality as the subjective experience of the sacred, while health care educators and professionals consistently assess spirituality as a person's internal sense of purpose, coherence, and a search for meaning in life. Despite the lack of a consensual definition, many analysts include the elements of transcendence, meaning and purpose in life, inner strength, connectedness, higher power, and caring relationships into their perceptions of spirituality. In attempting to consolidate such diverse views, one analyst recently defined spirituality as a motivational-emotional construct that refers to a desire to seek and to maintain meaningful integration within oneself (innerconnectedness), with other people and the world (human compassion), and with a sacred force outside oneself (connectedness with nature). In effect, spirituality is a personal quest for ultimate meaning, for a relationship with significant others, and with a transcendent force or higher power.

Thus, spirituality and religiousness are interrelated but not identical concepts. Although religiousness may be an outward manifestation of spirituality, spirituality can exist in the absence of religiousness, while religiousness does not guarantee a developed spirituality. In a study of self-definition of spirituality and religiousness reported during 2002, it was found that 32% of university students indicated they were both spiritual and religious; another 32% indicated that they were spiritual but not religious; 8% indicated they were religious but not spiritual; and 28% indicated they were neither spiritual nor religious. This study reveals the extent of public awareness and consciousness surrounding spirituality and religiosity and the need to clearly distinguish between them. Toward this end, the concept "humanistic spirituality"

is used here to refer to spirituality, and the concept "religiosity" to refer to the traditional definition of religiousness.

Measurement of Spirituality

The renewed perspective on the conceptualization of spirituality brings with it the challenge of constructing measures that are accurate and precise (reliability) and that the scale measures what it is claimed to measure (validity). Much of the impetus for measurement from the health sciences was spearheaded by the Fetzer Institute. In response to this initiative, a number of unidimensional and multidimensional scales of religiosity and spirituality were developed. To assess the unidimensional nature of spirituality independent of religiosity, the Spiritual Meaning Scale, a 20-item measure of theistic ("The goals of my life grow out of my understanding of God") and nontheistic ("My spiritual beliefs give meaning to my life's joys and sorrows") spirituality, is used. Another 20-item scale, the Spiritual Well-Being Scale, measures religious well-being (a sense of well-being in relation to God) and existential well-being (one's sense of meaning, purpose, and satisfaction with life). These measures reflect the contemporary distinction made between the constructs of religiosity and spirituality.

Two multidimensional measures extend the construct of spirituality. The 28-item Spirituality Assessment Scale (SAS) consists of four dimensions: purpose and meaning in life, inner-resourcefulness, unifying interconnectedness, and transcendence. A 24-item Spiritual Transcendence Scale (STS) consists of three dimensions of humanistic spirituality: innerconnectedness, human compassion, and connectedness with nature. The new scales reflect significant improvements in the conceptualization and measurement of religiosity and spirituality. The authors of all scales report good to very good psychometric properties. One of the key empirical contributions is the demonstration that measurements that claim to measure spirituality do, indeed, measure spirituality independent of measurements of religiosity. Moreover, the personality dimension of "openness to experience" is positively related to measures of spirituality, but is negatively related to measures of religiosity. Such findings provide some support for the notion that spirituality embraces freedom of expression, whereas religiosity tends to inhibit it, leading to the conclusion that spirituality and religiosity are distinct constructs that need to be assessed separately.

Spirituality, Health, and Death Attitudes

In recent years, empirical studies have identified significant links between spirituality/religiosity, physical/mental health, and death attitudes. Death poses an abstract and uncertain reality of the human experience. Spirituality serves as one means to address existential concerns associated with one's death and the attitude one takes toward death. But empirical investigations of spirituality and attitudes toward death are few in number, and early studies were conducted within the intrinsic/extrinsic religiosity paradigm. These studies show that intrinsic religiosity (religious belief) is associated with low death anxiety, whereas the relationship of extrinsic religiosity (religious behaviors) to death anxiety is nonsignificant or even positively related to fear of death. More recent research pertaining to negative and positive attitudes toward death in older adults shows that an intrinsic religious orientation is positively related to acceptance of death, while an extrinsic orientation is positively related to fear of death and death avoidance. More importantly perhaps, purpose in life rather than intrinsic or extrinsic religiosity is found to be positively related to subjective well-being and negatively associated with fear of death and death avoidance.

Intrinsic religiosity may be considered to be more closely related to spirituality in that intrinsic religiosity reflects a belief in, and a commitment to, a higher power that provides a sense of meaning and purpose in life. This suggests that it is the strength of the faith, the belief, or the commitment inherent in intrinsic religiosity that is more important in alleviating death anxiety and fear of death than are religious affiliations or religious behaviors per se. A similar pattern emerges when the relative contribution of spirituality and religiosity to death attitudes are examined; that is, spirituality is negatively related to death anxiety, whereas religiosity is not related to death anxiety. In addition, recent studies have shown that the construct of meaning in life mediates the relationship between spirituality and subjective well-being, whereas no such mediating effects are found for religiosity.

Spirituality, Loss of Significant Other, and End-of-Life Care

Spiritual exploration and spiritual questioning often arise in the context of the loss of a significant other through bereavement and grieving processes or with one's own impending death. The individual's desire to understand their location in the order of things leads to a need to feel connected with others. Spirituality reflects a self-directed approach and quest for personal meaning and answers to spiritual questions that assist with alleviating existential angst. Indeed models of health care, palliative care, and hospice care recognize the importance of spiritual issues.

Spirituality is an essential component in the care of patients with life-threatening illnesses and those who are dying. Their beliefs and values can contribute to a fuller self-understanding of their illness. Furthermore, in the caregiving and care-receiving relationship, it is not only the patient's spirituality, but also that of the caregiver that is important. Caregivers who understand their own spirituality can offer compassionate care and foster a sense of connectedness with patients that can facilitate the healing process. The biopsychosocial-spiritual model of care, utilizing the holistic approach to all four dimensions of the human experience, offers an essential pathway for integrating spirituality into health care. However, it is important to enhance spiritual care education and training in interdisciplinary spiritual care practices.

In summary, spirituality and religiosity are related but not identical constructs. They are similar in that both involve a search for the sacred or a higher power. They are different in how the search for the sacred is actualized through a personal search for meaning versus organized religious beliefs, rituals, and practices. Spiritual exploration and spiritual questioning are particularly salient in the context of existential concerns with personal death, the loss of significant others, and life-threatening illnesses. The biopsychosocial-spiritual model of care offers a promising approach to address these issues.

Gary T. Reker

See also Awareness of Death in Open and Closed Contexts; Bereavement, Grief, and Mourning; Caregiving; End-of-Life Decision Making; Grief, Types of; Hospice, Contemporary; Palliative Care

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Spontaneous Combustion

Spontaneous combustion occurs when an object self-ignites. The cause may be chemical, as when lithium oxidizes explosively in water, or biological, as when a haystack catches fire due to heat generated from bacterial fermentation. There is no scientific evidence that the human body can self-ignite. However, spontaneous human combustion (SHC) as an alleged cause of death has a long and controversial history. If true, the mechanism of ignition is mysterious and challenges what we know about the human body.

Cases accredited to SHC tend to have features in common. Most victims are female. Many are overweight, alcoholic, and have a mobility dysfunction or disabling illness. Usually there are no witnesses to the combustion and no calls for help are heard. The torso is badly burned, while

extremities, such as the lower legs, are left intact. The immediate environment suffers little damage although a foul-smelling yellow oil may surround the body. Often there is a significant time lapse between the victim being last seen alive and the finding of their charred remains.

Apart from possible accounts in the Bible, the first description of SHC in Western culture has been attributed to Danish anatomist Thomas Bartholin (1616–1680), founder of the journal *Acta Medica et Philosophica Hafniensia,* who described the case of a Parisian woman incinerated in her sleep while the straw mat on which she lay sustained little damage. In 1763, Jonas Dupont collected such stories in *De Incendiis Corporis Humani Spontaneis,* raising the public profile of the phenomenon.

Public interest in SHC has been utilized by writers as a dramatic literary device. Possibly the earliest example can be found in Charles Brockton Brown's (1771–1810) novel *Wieland* published in 1798. The most famous is the death of Mr. Krook in Charles Dickens's (1812–1870) *Bleak House,* first published 1852–1853 and forming part of the debate about SHC that raged in 19th-century England. SHC has been the subject of sustained interest in more recent times since the death of Mary Reeser in Florida, in 1951, at the age of 67, popularly accredited to SHC.

Seventeenth and 18th-century explanations for SHC favored alcoholism as the cause, believing (erroneously) that "alcohol-saturated" flesh was readily combustible. The more speculative contemporary explanations include kundalini fire, geomagnetism, ball lightning, and force fields from high-tension wires. Quasi-biochemical accounts such as "pyroton" particles initiating a nuclear chain reaction within the human body, ignition of cellular hydrogen and oxygen, and mechanisms associated with phosphorous metabolism have been dismissed by scientists as, at best, misinformed. Two explanations based on known scientific principles have met with less general skepticism and account for at least some of the phenomena associated with SHC: the static flash fire hypothesis and the candle or wick effect.

The human body can generate static electricity, and Professor Robin Beach, formerly of the Brooklyn Polytechnic Institute, suggested that some people can generate up to 30,000 volts at a time, which may singe or burn clothing on discharge. Moreover, there is some evidence that static discharge from people may ignite fires in some highly flammable environmental conditions. However, Beach's research demonstrated that the human body can hold an extremely high charge of static electricity without harm, so it is unlikely to cause a person to self-ignite in the way implied by SHC.

Possibly the strongest candidate explanation is that clothes saturated with melted human fat from an already burning body function like the wick of a candle, maintaining a slow but steady burn that cremates the fattier parts over several hours. Dr. John deHaan, a Fellow of the American Board of Criminalistics, demonstrated the wick effect on the BBC One program QED in 1998. The body of a dead pig—an animal with a similar fat content to the human body—was wrapped in a blanket and set alight using a small amount of petrol. The experiment showed that the pig's bones could be incinerated within about five hours.

The wick effect requires external ignition, an ineffectual and possibly slow reaction on the part of the victim, and time and poor ventilation to allow the smoldering flame to incinerate parts of the body. In cases of alleged SHC, these conditions are often met. Cigarettes, cigars, or a pipe are sometimes found near the body and an accelerant reaction from alcohol spillage or from highly flammable clothing is possible. Failure to extinguish the original flame can be accounted for by an alcohol- or drug-induced stupor, old age, disability, or death prior to incineration, as when the victim had suffered a heart attack or when fire may have been used to cover a murder. Moreover, victims are often socially isolated and found in poorly ventilated rooms. The ignition point of human fat is relatively low, and a human body can be incinerated at temperatures much lower than used in crematoria given time, poor ventilation, and porous bones (as in osteoporosis) with a smoldering fire unlikely to spread to surrounding areas or to draw immediate attention. The wick effect also explains why it is usually the fattier parts of the body that sustain the greatest damage.

Alleged cases of SHC are rare today. Forensic science is better able to explain immolations and it is likely that with additional, accurate information, many cases of alleged SHC would be explainable as tragic accidents or murders. To be taken

seriously, unusual claims require unusually strong supporting evidence, and the onus is on the exponents of SHC to prove the phenomenon beyond reasonable doubt. Until then, it seems prudent to follow the dictum of Occam's razor, which counsels acceptance of the simplest, most parsimonious explanation. Moreover, it is known that stories lending themselves to a dramatic interpretation, such as an unusual and gruesome death, are often developed in this direction in the telling. Hence, until a mechanism is proven for human self-ignition, it seems reasonable to assume that an external source is responsible.

Anna Madill

See also Accidental Death; Cremation; Forensic Science; Homicide; Literary Depictions of Death

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Spontaneous Shrines

Leaving flowers, candles, teddy bears, hearts, or cards on sites where people died a violent death has become a regular practice since the 1990s, at least in the Western world. In academia, it has become custom to refer to such commemorative sites as "spontaneous shrines," a term coined by Jack Santino. Murders, traffic deaths, work-related accidents, terrorist attacks, or disasters of human or natural origin may trigger people to bring attributes to the place of mischief in commemoration of the deceased. Other deaths that may evoke similar responses are the deaths of public figures (celebrities, royalty, politicians), although spontaneous shrines will generally appear on places associated with the deceased rather than on the place of their death.

All spontaneous shrines, whatever the reason of their taking shape, share the public dimension: exceptional deaths of ordinary people in the public domain as well as natural deaths of public people in the confinement of their private domains are "public events." This explains why people without a formal or personal relationship with the deceased may feel invited or compelled to express their grief, anger, or empathy in public. Many of the attributes that constitute spontaneous shrines are also placed on graves. However, spontaneous shrines differ from graves in three important respects. First, there are no bodies. Second, the public dimension sets spontaneous shrines and related ritual apart from funeral ritual, which is usually confined to the intimate sphere of friends and relatives. Third, spontaneous shrines arise on neutral, public places that are not formally reserved for mourning.

Disagreements Over Terminology

Santino chose the adjective *spontaneous* to highlight the unofficial nature of the commemorations performed. No authorities or institutional organizations initiate or encourage the erection of spontaneous shrines; instead, such sites result from people's personal motivations. Some scholars have objected that spontaneous shrines are not the outcome of "instantaneous" impulses, however, and approach spontaneous shrines as ritualized practices. In this view, spontaneous shrines, irrespective their unofficial nature, arise along the lines of what people deem to be the most appropriate and customary response to violent deaths. To avoid misinterpretations, scholars often choose other adjectives instead of *spontaneous,* most of which emphasize the transient nature of such sites. *Makeshift memorials*, *ephemeral memorials,* or *temporal memorials* are other expressions to refer to the same phenomenon, and may also be used in common language.

Approaching these sites as places of communion between the dead and the living, Santino prefers the term *shrine* above *memorial*. Shrines share this ability to offer communion with all other material objects and places that carry memories of the dead. Therefore, this communal quality is not specifically restricted to shrines. Monuments, memorials, and graves also connect the dead with the living through a physical location. Understanding why certain places continue to attract people over long periods of time while others pass into oblivion requires social, cultural, religious, and political

contextualization. Many scholars writing on the subject prefer the term *memorial* above *shrine* because the religious connotations of the term may contain the danger of obscuring significant differences in practice, form, and experience with unambiguously religious sites.

Public Mourning

Public mourning, of which spontaneous shrines are a contemporary expression, indicates the impact that certain deaths have on society. Deaths that may bring about large-scale public involvement are the deaths of public figures and the multiple deaths of ordinary people in shocking events. The deaths of celebrities, sports stars, singers, or politicians may deeply impress fans or supporters, particularly when perceived as untimely. In the case where a public figure dies a violent death, the societal impact is often broader and more intense, and may inspire more people to participate in the public mourning.

The massive response to the death of Princess Diana in 1997 brought the topic of spontaneous shrines inescapably to the attention of social scientists, journalists, and the wider public. The images of the immense heaps of flowers and the mourning crowds at the gates of Kensington Palace found their way around the globe. Many, including but not limited to British people, wondered how to understand this apparently unprecedented outpour of public grief. As a consequence, the mourning for Princess Diana has been quite extensively researched from a variety of angles. Much writing on spontaneous shrines takes the Princess' death as a starting point, historically as the first example that set the trend or rhetorically to introduce the subject. An unusual combination of ingredients, that is, the Princess' high media profile, the bizarre circumstances of her death, the criticism toward the royal family, and the permanent media coverage, added up to a public response of new scale and intensity. Yet spontaneous shrines have occurred earlier, for example, as part of the response to the murder of the Swedish Prime Minister Olaf Palme in 1986.

To a certain extent "the public" has always been present in the ritual following upon the death of public figures. Traditionally, the role of the public was rather passive and limited to witnessing the funeral procession. Spontaneous shrines and related ritual are different in resulting from an uninvited, active involvement of private citizens outside any formal protocol.

Since the mid-1990s, an increasing number of violent incidents or disasters that brought about the deaths of—smaller or larger—numbers of ordinary people have been commemorated through spontaneous shrines and other public mourning ritual. Examples of events that received worldwide attention were school shootings, the terrorist attacks on the World Trade Center and the Madrid Trains, and the 2004 Southeast Asia Tsunami. Important for the public to get involved in the mourning is the extent to which a death or multiple deaths attract media attention, and the way the media frame the incident as a societal issue. Spontaneous shrines often coincide with media hype, which is not to say that the sentiments are void or meaningless. Mass media also play a vital role in shaping ritual and disseminating new formats of mourning and commemorating.

Roadside Memorials

Most spontaneous shrines are roadside memorials. These memorials for traffic casualties are generally initiated by the victim's close friends and family, without the involvement of a wider public. Leaving aside accidents that are exceptional in, for instance, the number of deaths, media coverage of traffic tragedies generally remains local and low profile. As a phenomenon, roadside memorials are gaining in importance in many Western countries. Nevertheless, to place this development in proper perspective, it should be kept in mind that roadside memorials are erected for only a fraction of the world's annual traffic casualties.

Roadside memorials are often interpreted as continuations of Catholic memorial crosses. However, the present-day roadside memorial is not restricted to Catholic areas at all, and there are important differences between the two memorial practices. Memorial crosses were erected for those who had died unexpectedly along the road, and consequently had to appear unprepared before God's throne. Short texts on the cross encouraged passersby to pray for the salvation of the unfortunate's soul. Today's roadside memorials are not based on such theological considerations. Instead, they articulate the increasing experience of traffic

death as unnatural, particularly when it strikes young people. Although frequently used, the cross has for many become rather a sign for death, loosened from its original religious meaning. This demonstrates the need for caution in explaining present-day expressions of mourning as a continuation of earlier practices in a new context.

Many roadside memorials start out as a few bunches of flowers and some candles along the road, demarcating the place of the victim's death. Yet the effort it takes to maintain a roadside memorial that consists exclusively of ephemeral objects for an extended period of time is a problem that comes with any spontaneous shrine and makes many people turn to more solid solutions. Crosses, slabs of stone, boulders, pebbles, decorated posts, or perennial plants, sometimes in combination with a plaque, are the main constituents of many roadside memorials. In some countries, it has become customary to include the tree against which the victim crashed in the memorial, while elsewhere these trees may become the target of people's grief and anger, and are cut or damaged.

In order to keep control of the growing number of more or less permanent roadside memorials, many local and national authorities have developed rules and regulations about their size, duration, maintenance, and location. Roadside memorials also evoke objection and aversion. One common objection is that roadside memorials distract the attention of drivers, and therefore are dangerous. Another is that it is disturbing to be confronted unsolicited with death or the sorrow and grief of others. The regulations imposed—restricting diversity and visibility—are often at odds with the desire of the bereaved for an individual, self-styled expression of their emotions. However, in spite of all striving for individuality, roadside memorials are ritualized practices in which an individual touch is but one requirement.

Moreover, when trying to understand the current proliferation of roadside memorials, it is important to realize that the horrendous fact of the daily road deaths and injuries alone does not offer a sufficient explanation. In most Western countries the traffic "death toll" has decreased drastically over the last 30 years. Apparently, popular sentiments are not rooted in statistics. Consequently, roadside mourning and related forms of public commemorative ritual are specific for our era, and therefore should be analyzed in a broader societal context.

Rituals of Protest

Spontaneous shrines are part of a broader repertoire of mourning ritual. In many cases, the bereaved, or others who feel involved with the tragedy, hold a wake or service at the memorial site or organize a (silent) march to express their grief and anger. Next to these concrete public performances, web-based condolence registers and virtual memorials also become common elements of the ritual repertoire of public commemoration.

Violent death may happen unpredictably, and the reactions of the public and the subsequent media coverage can be anticipated. Yet, we should not conclude from the similar appearances of such responses in many places of the world that they imply similar intentions or meanings. Behind the shared repertoire lie different worlds of messages, morals, and politics that are deeply embedded in local societies.

Apart from being expressions of mourning, spontaneous shrines are also material articulations of political messages or even protests. In addition to their unorganized "coming into being," this is another significant dimension in which spontaneous shrines differ from graves and other places that are specifically destined for mourning ritual. Although graves and spontaneous shrines both prolong the social presence of the deceased, in the case of graves this remains limited to the personal perception shared by family and friends (deceased celebrities excepted). Spontaneous shrines are always also material testimonies of the cause of the victim's death. A spontaneous shrine imposes a more societal or political identity over the deceased's personal identity, namely that of being a victim of a specific type of social evil or (natural) disaster. By bringing attributes to the place of mischief, signing a condolence register, participating in a wake, or joining a march, the participants make public statements about a specific, contemporary, moral, and political issue. Through the ritual, the participants present themselves to the outside world as a moral community, implicitly excluding the evil ones from this community.

Irene Stengs

See also Accidental Death; Memorials; Memorials, Roadside; School Shootings; Sudden Death

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Stephenson's Historical Ages of Death in the United States

People collectively construct meanings, images, and rituals for coping with the mystery and inevitability of death. In the United States, as in all societies, these collective images and rituals for coping with death have changed drastically over time. Beginning with the original New England colonies during the 17th century, John Stephenson, in *Death, Grief, and Mourning: Individual and Social Realities,* demonstrates how the images of death and the rituals associated with death and the dying process proceeded through three stages: the age of sacred death, the age of secular death, and the age of avoided death.

John Stephenson describes how over the last four centuries, the collective meaning of death shifted in the United States. Thus, the collective interpretation of death evolved from a sacred process, embedded in the Puritan eschatology, to a secular process, premised on science. Then, as the U.S. society transitioned into modernity, individuals institutionalized and bureaucratized the dying process while removing it from public life. The three historical ages of death in the United States represent not static points in history, but rather dynamic processes wherein culture and institutions intersect. This entry highlights Stephenson's assessment of the social processes that influenced the image and rituals of death within each of the three historical ages of death.

Collective Image of Death and Social Processes

Exactly what death means for society is contingent upon the social context. Death is understood in terms of the value system held by members of the social environment. Individual images of death reflect the collective image of death. It is this collective image that defines each historical stage of death in the United States, a collective image that is associated with the social, political, economical, cultural, and demographic context and processes.

Age of the Sacred Death

Stephenson indicated that the sacred age of death in the United States arose in the Puritan colonies of New England during the early 17th century. The religious meanings associated with death and the dying process caused death to have a sacred meaning. People died as the result of sin, and upon dying, they had to account for their sins on earth. During this stage of death in the United States, people understood why they died and what was to be expected in the afterlife.

Early Puritan society consisted of small, tight-knit communities where religion and family were central to social life. Low life expectancy rates resulted from high rates of disease, occasional epidemics, and poor health care in the colonies. Infant and child mortality rates were high. At least one out of four of the infants who survived their 1st year did not live to see their 10th year. Considering the closeness of the Puritans and the high mortality rates, death rarely went unnoticed. Death was always on public display within everyday life.

Puritan beliefs defined the collective image of death during this period of sacred death. Central to the Puritan doctrine was the notion that only a few people would enter the Kingdom of God, and only God knows of those chosen few. With afterlife predetermined, individuals had no guarantee that they would enter the Kingdom of God upon their death. Thus, death was a source of extreme fear and anxiety. Not only did people fear death, religious doctrine mandated fear. Therefore, the

dying process was a time of severe terror of one's impending doom and eternal damnation.

Although grim, this collective image of sacred death provided a clear explanation for the dying process, death, as well as the afterlife. Neither death nor the afterlife was a mystery for the Puritans. In accordance with the Puritan eschatology, suffering was a condition of the earthly life, whereas heaven was the place free of suffering. One needed to work hard and live a meager life while devoted in worship.

While the collective image of death during the age of sacred death manifests in the rituals for death, so too did the rituals during dying process, the funeral ceremony, and the rituals for disposing of the body shift in accordance with these collective images of death. Individuals cherished the physical life and feared the afterlife during the age of the sacred death. Therefore, the focus of the dying process was on the dying individual rather than the bereaved survivors. Death was a reality observable in daily life, was rarely sudden, and therefore, people usually knew of their immanent death well before their final moments. Furthermore, the dying process during the age of sacred death was a public ceremony. Upon the awareness of the individual's impending death, the room of the dying would transform into a public place where friends, family, acquaintances, and other members of the community would visit with the dying.

During the age of sacred death, the family prepared the deceased for burial, delivered the body to the gravesite, and buried the body. Survivors did not mark graves with gravestones because the grave was only thought to be a temporary holding area for Judgment Day. Survivors avoided any recognition of the grave or memorial of the deceased as it emphasized the earthly life, not the spiritual life. Rather, the public acknowledgment of the deceased occurred during the sermon on the Sunday following the modest burial.

Age of the Secular Death

The age of the sacred death did not give way to the age of secular death until the turn of the 19th century. Stephenson enumerated several factors that led to the transition from the sacred death to the secular death. At the turn of the 19th century, the Industrial Revolution marked the introduction of factories resulting in mass urbanization and the subsequent rise of the U.S. metropolis. As the United States moved toward modernity, it brought with it prosperity; wealth increased, the quality of life rose, infant mortality rates slowly declined, and life expectancy increased. Science and technology replaced religion as the authority of the day. The political power of the Protestant Church and its doctrine declined. And as wealth and commerce increased, people began looking toward the economy for security rather than the family and community as in times past.

As social, political, and economic life in the United States underwent profound changes, so too did the collective image of death. People believed death no longer resulted from sin. Because science had the tools to control nature, people no longer believed God controlled human destiny. Consequently, religion had less influence on the collective image of death. As U.S. values shifted from religion to science, the underlying ideologies associated with death also shifted from religious to scientific. During the secular age of death, individuals adopted scientific logic as the standards, and thus, life and death shed its sacred meanings. People reinterpreted death as simply a natural, unpredictable occurrence that provided no resolution for the survivors.

Furthermore, by the turn of the 19th century, as the collective image of death and life lost its sacred meaning, the collective image of God began to shift—even within the Protestant Church. Whereas during the sacred age, God was perceived as angry and vengeful, He was now seen as a kind, gentle, and forgiving God. This new image of God took the sting out of death because everyone—even the wretched sinner—could enter into the Kingdom of Heaven. Because death assured a person's place in heaven, death no longer represented terror and angst, but rather a joyous and celebratory occasion.

The meaning of cemeteries shifted during the secular age in that cemeteries provided inspiration and immortality for the living. They were public displays, serene garden-like areas with highly decorative gravestones and detailed imagery and inscriptions representing eternal peace and heavenly splendor.

This shift from the collective image of the sacred death to the image of the secular death produced shifts also in the focal point of death, from the

deceased individual to the bereaved survivors. People thought that with diligence and hard work, everyone could achieve the American Dream. Because humanity was now perceived as its own provider, individuals had to provide for their families both in life and in death. Therefore, individuals sought rational ways for providing such security through earthly, rational means, such as savings, life insurance policies, and trust funds.

The age of secular death marked a time of significant mourning rituals. The increasing secularism coupled with the increasing pace of urban life and the expansion of the metropolis resulted in the decline of emotional support within the family and community and an increase in social isolation and alienation. The shift of focus from the deceased to the survivors as well as the inconsolable sorrows of losing loved ones contributed to the increase in elaborate mourning rituals during the age of secular death. The survivors expected to spend long periods in mourning for loss of their loved ones.

The funeral ceremonies during the age of secular death were elaborate, depressing, and poignant public events that focused on the bereaved survivors. Survivors displayed their sorrows not only through emotions, but also through the adornment of symbols of grief, such as solid black clothing, armbands, or badges. Furthermore, with wealth and materialism, funeral ceremonies became venues for displaying social status.

As the popularity of elaborate funeral ceremonies increased over the course of the 19th century, a division of labor arose for managing the death rituals. By the end of the 19th century, these rituals for death were a lucrative industry. In the early 19th century, the family began relinquishing the burial preparations to skilled nurses, furniture stores built and sold coffins, and funeral directors or undertakers managed the funeral ceremony and burial. Whereas the family ultimately prepared the deceased for burial, delivered the body to the burial site, and buried the body during the age of the sacred death, during the age of secular death the family outsourced the logistics of the funeral ceremony and burial to specialists.

Cemeteries, too, reflected the shift from the deceased to the bereaved survivors. While often located in isolated areas close to a church during the sacred age, during the age of secular death, cemeteries became memorials for the deceased was well as material items to assist in the grieving process. And while uncommon during the age of sacred death, gravestones during the secular age depicted the grief and sorrow of the survivors through inscriptions about the survivors of the deceased or in remembrance of the deceased.

Age of the Avoided Death

The end of World War II signified, among other things, a transition from the age of secular death to the age of the avoided death—the age of death in contemporary America. According to Stephenson, the collective image of the secular death remained the same as in the previous era. What makes this era unique from previous ones is that American society removes death completely from everyday social life. The collective image of death as taboo and, consequently, the removal of the dying process and death from public life through the institutionalization of all aspects of death and the dying process characterize the age of avoided death in the United States.

Death no longer is an everyday reality. The institutionalization and bureaucratization of death that began in the previous era came to fruition during the mid-20th century. Hospitals, hospices, and nursing homes steadily replaced the role of the family and community in the dying process, and morgues, mortuaries, and funeral homes steadily replaced the role of the family and community once death occurred. Whereas in previous eras, the dying process was a public event, death during the age of avoided death occurs behind closed doors in institutional settings, where the dying usually dies alone. Furthermore, the inordinate amount of military and civilian casualties resulting from the two World Wars during the first half of the 20th century marked a cultural shift in the grieving and mourning rituals in the United States. Whereas the rituals for coping with the loss of loved ones involved highly emotional, public ceremonies and long periods of mourning during the age of secular death, survivors now avoid grief and mourning rituals.

However, these structural factors alone do not fully explain why individuals avoided death. As the structural factors changed, so too did American values. The current image of death stands in stark contrast with many core American values, among them a belief in the science and technology for

mastering nature, success, progress, materialism, and rationality. First, as science and technology can, at best, extend the dying process, death represents the failure of science and medical practitioners. Death contradicts the notion that humans can solve everything and conquer nature through science and technology. Second, as people view death during this era as a natural process, it is devoid of meaning. Death and dying therefore result from individual failure—the inability to maintain oneself. Third, a principle component of success in the United States is material wealth. Everything is possible as long as you have the money to pay for it. Death contradicts this belief. All the money in the world cannot exempt anyone from death. Finally, as death is irrational, it clashes with the American value of logic, explanation, or method.

As individuals are unable to reconcile the image of secular death with the American value system, the thought of death produces fear and anxiety. Rather than coping with these irreconcilable differences, contemporary American society hides the dying process behind the institutional walls of the hospital, hospice, and nursing homes. Highly formalized bureaucracies such as morgues, mortuaries, and funeral homes now handle the death rituals.

However, the avoidance of death in contemporary America does not end with the institutionalization of death and dying. Individuals, even those dying, should ignore death, or even deny its inevitability, at all costs. When informed of their impending death, the dying should accept it discreetly. Prohibited is excessive emotional behavior, courageous and dignified are those people who die silently.

Similarly, survivors must show a lack of emotion, demonstrating a courageous, strong, and honorable front. Survivors can only express grief in private or during institutionally prescribed times, such as during the funeral ceremony. Talking about death is morbid and negative; rather, individuals should ignore the dying process as well as death.

The funeral ceremony within the age of avoided death makes death appear avoided. The funeral director has the task to breathe life back into the deceased, if only to give the impression that the person is sleeping. With embalming methods and cosmetics, the deceased appears alive for the viewing, to look just as good—if not better—than they did before they died. Subtlety, too, is the defining feature of the contemporary cemetery. As death is now a cultural taboo, no longer do cemeteries use elaborate statuaries or tombs.

Jason Milne and Steven J. Seiler

See also Ariès's Social History of Death; Bereavement, Grief, and Mourning; Causes of Death, Historical Perspectives; Cemeteries; Death, Sociological Perspectives; Death Anxiety; Funeral Industry

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Subintentional Death

Within the death and dying literature, subintentional is defined as indirectly or unconsciously causing one's own death. Many experts such as Normal Farberow, cofounder of the Los Angeles Suicide Prevention Center, believe that subintentional death and suicide exist along a continuum. At one end of the continuum is direct, overtly

suicidal behavior. The individual communicates unhappiness and intentionally causes self-death. The actions are unequivocal, and often substantiated by a written note or a verbal declaration. At the other end of the continuum are indirect self-destructive behaviors that may shorten life whether or not conscious suicidal intent is present. These individuals may have no intention to die and may not consider themselves to be suicidal. The actions are equivocal, and include risk taking in driving and sports; poor physical care including medical noncompliance, disregard of preventive advice, and neglect; nonlethal physical destruction, such as self-punishment and self-mutilation; unprotected sex; pathological gambling; and abusing alcohol or drugs. It is important to examine theoretical understandings of subintentional death, research on this important topic, and society's attitudes toward subintentional death.

Theories

Theoretical understandings of subintentional death began about the early 1900s, when sociologist Émile Durkheim classified indirect self-destructive behaviors as embryonic forms of suicide. The psychiatrist Sigmund Freud considered ordinary mistakes, errors, minor accidents, bungled actions, slips of speech, and other cases of forgetting to indicate unconscious suicidal wishes. Robert Firestone posited that self-limiting, self-destructive behaviors are based on powerful self-hatred and negative self-attitudes incorporated by the child during formative years.

Edwin Shneidman in 1968 coined the term *subintentional death* and developed four subtypes. Death chancers leave the outcome to chance, such as fundamentalist snake handlers and those who practice autoerotic asphyxia. Death hasteners bring about their own deaths through lifestyle choices and treatment noncompliance; they disregard medical recommendations, such as eating excessive sweets although they are diabetic. Death experimenters pursue altered consciousness, such as chronically abusing alcohol or drugs. Death capitulators give up, such as individuals who die after a voodoo curse.

Developmental theorists, such as Diana Baumrind, note that risk taking is part of normal adolescence. Developmentally constructive risk that promotes growth includes adaptive experimentation, which builds confidence, enhances competence, develops initiative, promotes autonomy and mastery, and hones skills essential for the transition to adulthood. In contrast, pathogenic, deviant, life-threatening risk taking potentially jeopardizes health and life.

Biological theories attribute risk taking to hormonal influences and genetic predispositions. In support of this understanding is that testosterone levels rise during adolescence; at the same time, risk taking increases. In addition, alcoholism runs in families, and risk taking appears to do so as well.

Psychological and cognitive theories note that optimistic expectations influence how people perceive risk and feel invulnerable. People with high tendencies toward sensation seeking take physical and social risks simply for the sake of the experience. For example, they might enjoy bungee jumping. Further, compared to others, they expect more positive outcomes, process novel or intense stimulation differently, have higher thresholds for pain, are more susceptible to boredom, and have unusually low levels of arousability.

Research Findings

Some research exists on subintentional death. A longitudinal analysis by Jan Neeleman in 1998 of a general-population birth cohort born in 1946 indicated that conduct disorders and aggression, and to a lesser extent emotional instability, raised the risk not only for suicide but also for premature death from accidents as well. This finding is consistent with the hypothesis of a continuum between subintentional and intentional self-destructive behavior.

Several questionnaires inform research on subintentional death. The 84-item Firestone Assessment of Self-Destructive Thoughts (FAST) includes 11 levels of progressively self-destructive thoughts (e.g., You're incompetent, stupid). The FAST has uniquely pragmatic instructions to report how frequently a person has various negative thoughts directed toward themselves. The second-person format illustrates elements of a self-destructive process that may have been partially or completely unconscious.

Designed for a specific population, the 20-item Harmful Behaviours Scale (HBS) developed by Brian Draper and colleagues includes a broad array of behaviors, such as refuses to eat or

drink, irrespective of their motivation. In one study where nursing home staff completed the HBS, residents fell into four groups: aggressive or resistant, food refusal, behaviorally disturbed, and nonsymptomatic. The behaviorally disturbed group engaged in a widespread combination of direct and indirect self-destructive behaviors and displayed other behavioral and psychological symptoms of dementia. In contrast, the food refusal group had the most cognitive impairment, but no higher depression or suicidal ideas. Among nursing home residents, indirect self-harmful behaviors were most often associated with dementia.

Also, the How I Deal With Things Scale developed by Martha Burt and Bonnie Katz asks women to rate how frequently they used 33 different coping behaviors in dealing with adult sexual assault. Its Self-Destructive subscale is comprised of eight items about behavioral acting out or escapist coping (e.g., Drank a lot of alcohol or took other drugs more than usual). Self-destructive coping is associated with trauma symptoms following sexual assault.

Societal attitudes toward subintentional death are not necessarily grounded in theory or research. In general, people's attitudes toward subintentional death differ from their attitudes toward suicide. Except in rare cases of altruistic suicide and terminal illness with intractable pain, people typically condemn suicide and view suicidal people as psychiatrically disturbed. With subintentional death, in contrast, people respect individual right to choose, and may even glorify those who survive extreme adventure-seeking behaviors.

The idea in the term *subintentional death* is that the deceased person plays a role in hastening the death, such as exercising poor judgment by driving a car without bothering to fasten the seat belt. However, the distinction between intentional and subintentional death is not always clear, such as some cases of overdose where it is not clear whether the person knowingly ingested too many pills.

Lillian Range

See also Accidental Death; Assisted Suicide; Autoerotic Asphyxia; Mass Suicide; Psychache; Suicide; Suicide, Counseling and Prevention; Suicide, Cross-Cultural Perspectives; Suicide Survivors

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Sudden Death

Sudden death involves the unexpected or untimely death of an individual. The term is commonly used to refer to sudden cardiac death—a natural death from cardiac causes, heralded by an abrupt loss of consciousness within one hour of the onset of acute symptoms. Other forms of sudden death may be noncardiac in origin. Examples include respiratory arrest, toxicity or poisoning, anaphylaxis, or trauma.

The sudden cardiac death concept incorporates the features of natural, rapid, and the unexpected. It does not specifically refer to the mechanism or cause of death. Common examples of unexpected natural deaths include deaths by heart attack, stroke, or ruptured aneurysm, death from rapidly progressive infectious diseases, sudden infant death syndrome, postoperative complications, pregnancy and postpartum, and natural disasters, including earthquakes, hurricanes, and floods.

Some sudden losses are the result of intentional acts, such as suicide and homicide. Also, deaths from bombings and acts of war and terrorism are intentional acts, although direct contact with the intended victims is not always present. Other deaths, such as vehicular homicide due to reckless or drunken driving, have a lesser degree of intentionality. The individual responsible for the death made a choice that resulted in another's death, but there was no premeditation. Finally, in the case of sudden death as a result of accident, there is no clear intentionality.

Some sudden losses may have a degree of expectedness. For example, the heart attack of someone at risk or the sudden loss of someone struggling with a life-threatening illness, even supposedly in recovery, may not be completely unexpected. Suicide is commonly described as a form of sudden, unexpected death. This view evolves from suicide survivors who report that they often feel unprepared and describe the event as a devastating emotional blow. Although suicide is sudden, the death is not always unexpected. This is because the decision to take one's life is frequently preceded by depression and psychiatric disturbances, the occurrence of diverse negative stressful events, and suicide warnings, threats, and/or attempts. Most individuals who commit suicide provide cues about their intention, and many suicide survivors recognize this to be the case.

Incidence of Sudden Death and Survivorship

The major forms of sudden death rank among the major leading causes of death in the United States today. In 2005, heart disease was the leading cause of death. Cerebrovascular diseases, including strokes, were the 3rd leading cause of death, while accidental death ranked 5th, suicide was 11th, and homicide ranked 15th among the leading causes of death.

The impact of sudden death on the lives of survivors is widespread. With nearly 1 million sudden deaths each year, researchers estimate that each sudden death affects 3 family members on average and 7 to 10 close relatives and other significant others. Based on these estimates, sudden death impacts 10 to 12 million survivors annually in the United States.

The Aftereffects of Sudden Loss

The suddenness of death can raise a number of complex issues for survivors. Research findings suggest that sudden death leads to more immediate and long-term coping problems among the surviving family members than deaths that are anticipated. Indeed, sudden death has been associated with frequent and persistent depressive syndromes, the onset of new illnesses or the exacerbation of existing illnesses, and increases in health-compromising behaviors, such as alcohol consumption and prescription drug use. Although survivors of sudden loss share many of the same general bereavement reactions as those of anticipated deaths, shock and denial are commonly associated with sudden death bereavement.

Grief following sudden loss is often intensified because there is little or no opportunity to prepare for the loss, resolve unfinished business, or say good-bye. The resultant grief reactions are intense and, in addition to shock and denial, the condition of yearning, separation pain, anger, guilt, sudden depression, despair, and hopelessness often result. Recent studies differentiate grief reactions across particular forms of sudden loss. Thus, while shock and denial are common among sudden death survivors, the results of comparative studies suggest that accidental death survivors report greater shock and denial than suicide survivors. Guilt, shame, anger, rejection, and the need to understand why are most characteristic of suicide survivors, whereas shock and disbelief, intense and prolonged sadness, guilt, rage, desire for revenge, fear, and self-blame are common reactions among homicide survivors.

Families may also experience multiple secondary losses, including the loss of income, the loss of home and business, and the loss of community status. When the body is not recovered, many legal and financial matters are left unresolved. Suicides, natural disasters, and mass shootings also may impact life insurance payments and create other legal liability issues.

The role that the loved one held within the family is gone, forever altering the relationships among the surviving family members. Family and marital relationships often become strained and disorganized and, in some cases, marriages end in separation or divorce. It is common for family members to believe that they are in a state of perpetual disarray with an enduring sense of unease and uncertainty about the future. It may take months and, in some cases, years for the family to reorganize and for relationships to heal.

The search for understanding and meaning of the loss also can challenge a survivor's religious or spiritual beliefs. The sudden death of a loved one can also provoke an existential or spiritual crisis that challenge one's faith or one's assumptions about life's meaning. Survivors may question their internal belief system and values. Goals, plans, and decisions that were important the week prior to the death abruptly seem trivial in comparison. Survivors are forced to re-evaluate life priorities that may lead to significant lifestyle changes.

Problems Unique to Sudden Death Survivors

Special problems arise if any of the grieving survivors were involved in or physically injured in an accident or disaster. Memories of the event tend to control the individual's thoughts. In some instances, the bereaved person may suffer from "survivor guilt," wondering why he or she survived the event when others died or believing that he or she could have or should have done more to prevent the tragedy.

Families experience difficulty in grieving and in reaching closure in those situations where no positive confirmation of the death occurs, when the physical body is not recovered, or when the family is unable to view the body. These circumstances make it difficult to grasp the reality of death as the bereaved continue to hope for the survival of their loved one. Only when the reality is fully understood can the bereaved move past the trauma to face the full realization and pain of the loss.

Reactions to sudden death can be further complicated if death is the result of a violent act, including suicide and homicide. One of the most agonizing kinds of death for family members to endure is suicide. Family members often blame themselves or are blamed for the death, resulting in feelings of shame, guilt, and anger. As a disenfranchised or publicly unacknowledged loss, suicide is often hidden so as to avoid the potential social stigma. The treatment homicide survivors receive as a result of the normal investigative process often leaves them aggrieved and alienated. During the initial questioning by police, it is not uncommon for homicide survivors to be considered early suspects in the murder of a loved one. Although survivors in these circumstances understand the importance of questioning family members as both witnesses and suspects, they nevertheless are frustrated with the process, and commonly perceive that valuable time is being lost in finding the real murderer. It is particularly difficult on the family if the killer of their loved one has not been caught.

The trial process is one of the most stressful experiences for homicide survivors, who often are surprised to find that neither they nor the victim are represented by the prosecutor or district attorney at trial. Further, homicide survivors are often unaware of the manner in which trials proceed, particularly in capital cases. Survivors learn that homicides do not always result in convictions and that sentences do not necessarily match the severity of the crime. Perceptions of injustice and a lack of respect for their loved one often cause further distress for the homicide survivor.

In public or particularly newsworthy events, such as natural disasters and mass shootings, survivors have to cope with the intrusion of the media. The media can become an additional source of distress—not respecting the family's privacy and replaying the tragic event on television. In the cases of suicide and murder, the media may even implicate family members as partly responsible for the deceased's actions or circumstances.

Contemporary Sudden Bereavement Research Issues

Important research findings indicate that sudden losses are distinct and, therefore, are likely to affect survivors in many different ways. Current research on grief and loss offers insight into the unique aspects of individual adaptation to coping with sudden loss, while also providing important clues or signs and symptoms of potentially serious complications that require prompt attention. An inability to function for weeks and even months after the death, abuse of alcohol and drugs, or symptoms of severe, major depression or post-traumatic stress disorder should all be addressed professionally and immediately, even if the person is grief stricken.

Although the available knowledge offers many important insights, the need exists for comparative studies that go beyond the prevalence of psychological distress across different bereavement groups; indeed, few studies have used nonbereaved control groups for enhancing understanding of the impact of sudden death on survivors. Such a limitation is

common, thus making it difficult to determine the relative severity of psychological distress among all family members. The use of retrospective data that are subject to the distortion of the facts, the forgetfulness of subjects, and the effect of recent stressors upon survivors also are known to affect how earlier experiences are remembered. Thus, longitudinal studies could provide some essential insights into how suddenly bereaved individuals who experience only transient reactions differ from those individuals who develop chronic abnormal symptoms.

Mark D. Reed

See also Accidental Death; Acute and Chronic Disease; Causes of Death, Contemporary; Economic Impact of Death on the Family; Sudden Infant Death Syndrome (SIDS); Suicide

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Sudden Infant Death Syndrome (SIDS)

In sudden infant death syndrome (SIDS; sometimes called "crib death" or "cot death") an apparently healthy infant under one year of age dies suddenly with no advance warning. SIDS deaths are distinguished from other infant deaths by the fact that the death remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history.

A diagnosis of SIDS is essentially a "diagnosis by exclusion," one made by ruling out all other possible causes and then recognizing some distinctive patterns. There are currently no definitive diagnostic indicators that unmistakably identify recognized abnormalities in an infant sufficient to cause a SIDS death. Nevertheless, there are some biological, clinical, and historical or circumstantial markers commonly found in this syndrome, including (a) tiny red or purple spots (minute hemorrhages or petechiae) on the surface of the infant's heart, in its lungs, and in its thymus; (b) an increased number of star-shaped cells in its brainstem (brainstem gliosis); (c) clinical suggestions of apnea or pauses in breathing and an inability to return to normal breathing patterns; and (d) a peak incidence at two to four months of age declining rapidly almost to nonoccurrence beyond one year of age.

Formal identification of SIDS as a syndrome—an identifiable constellation of events arising from an unknown cause—and its recognition by the World Health Organization as an official cause of death distinguish SIDS deaths from those caused by child abuse or neglect. This confirms that nothing could have been done ahead of time to prevent the death.

Incidence

During most of the 1980s and the early 1990s, SIDS accounted for the deaths of 5,000 to 5,500 infants each year in the United States. By 2004, however, the number of SIDS deaths had been reduced to 2,246. Nevertheless, SIDS remains the third leading cause of deaths in infancy (following congenital malformations and disorders related to short gestation and low birth weight). Approximately two-thirds of all infant deaths occur during the perinatal and neonatal periods (at the time of birth and during the first 28 days of life, respectively). Thereafter, SIDS is the leading cause of death in the United States among infants between 1 month and 1 year of age.

SIDS is a sudden and silent killer, often associated with sleep, but apparently involving no suffering. Characteristically, SIDS deaths show a pronounced peak in number during the colder fall and winter months of the year, especially during January through March in the United States or six months later in the southern hemisphere. Epidemiological studies suggest that SIDS may be associated with a detrimental prenatal environment, but infants at risk for SIDS cannot be distinguished from those at risk for many other health problems. In general, at-risk infants include those with low birth weight or low weight gain, as well as those whose mothers were less than 20 years of age, were anemic, had poor prenatal care, smoked cigarettes or used illegal drugs during pregnancy, or had a history of sexually transmitted disease or urinary tract infection. But none of these factors is sufficient to predict how, when, why, or if SIDS will occur.

SIDS appears in families from all social and economic groups, although African American infants are 2 to 3 times more likely to die of SIDS than Caucasian American babies. Approximately 60% of all SIDS deaths are those of male infants. The largest portion of SIDS deaths (approximately 70%) occurs in infants between 2 and 4 months of age, with most SIDS deaths (approximately 90%) taking place by 6 months of age.

SIDS-Related Research

Research on SIDS is extraordinarily difficult, facing problems that frustrate scientific investigators. For example, in SIDS there are no living patients to study because the first symptom is a dead baby. Also, risk factors for SIDS are not sufficiently strong or specific to permit identification of high-risk groups as subsets of the general infant population in which the natural history of a disease can be followed with smaller numbers of subjects. And there are no naturally occurring animal models for SIDS. As a result, SIDS is currently unpredictable and unpreventable, although it is possible to modify some risk factors for SIDS deaths.

Epidemiological and pathological research have dispelled numerous misleading and harmful myths about SIDS (for example, it is not contagious and does not run in families), while also ruling out many factors thought at various times to be causes of SIDS. For instance, SIDS is not the result of child abuse and it is not caused by vomiting and choking, minor illnesses such as colds or infections, or immunizations such as those involved in the DPT (diphtheria, pertussis, and tetanus) vaccines. Nor is SIDS the cause of every unexpected, sudden infant death.

Much attention has been given to the need for additional research on understanding the causal mechanisms behind SIDS. It is currently thought that brainstem abnormalities and neurochemical evidence might help to understand some infants' vulnerability to SIDS.

The "Back to Sleep Campaign"

In the early 1990s, research in Tasmania suggested that infants might be at less risk for SIDS if they were put down for sleep on their backs (supine) or sides, rather than on their stomachs (prone). That contradicted familiar advice favoring infants sleeping prone in order to reduce the risk of them regurgitating or spitting up fluids, aspirating them into their airway, and suffocating. The new research suggested that infants who sleep on their stomachs are at far greater risk of SIDS than they are of other problems.

In April 1992, the American Academy of Pediatrics (AAP) Task Force on Infant Sleep Position concluded that infants who sleep on their backs and sides are at the least risk for SIDS when all other circumstances are favorable (for example, when sleeping on a firm mattress without overheating, loose bed covers, or soft toys nearby). As a result, the AAP recommended healthy infants should be positioned on their sides or backs when being put down for sleep. Subsequently, the AAP revised its recommendation by emphasizing that positioning infants on their backs is the preferred position for their sleep at night and during naps, and by withdrawing approval for sleeping on an infant's side as an acceptable alternative.

In June 1994, a national "Back to Sleep Campaign" was initiated in the United States. This campaign, sponsored by the National Institute of Child Health and Human Development, is designed to employ literature, the media, and other avenues to raise professional and public awareness about the importance of sleep positioning as a way to reduce SIDS deaths. Dramatic and sustained reductions in SIDS deaths in the United States (over 45% from

1994 to 2004) and many other countries have been associated with initiatives like the "Back to Sleep Campaign" together with other proactive interventions, such as good prenatal care (proper nutrition, no smoking or drug or alcohol use by the mother, and frequent medical checkups beginning early in pregnancy) and maintaining a smoke-free environment after the baby is born, have had the effect of greatly lowering the risk that infants will die from SIDS.

Unfortunately, initiatives like these have not been applied equally in all racial and cultural groups in America. For example, less than optimal prenatal care is found in some sectors of our society. Moreover, African American mothers appear to be more likely than mothers in other racial and ethnic groups in our society to place their infants on their stomachs when put down to sleep. This reluctance to place infants on their backs for sleep appears to be directly correlated with less significant declines in SIDS death rates among African American infants than among infants in other groups in American society.

Bereavement After a SIDS Death

The unexpected death of an apparently healthy infant is most often perceived as a disruption of the natural order of things. A shocking event, it threatens the sense of safety and security in everyone it touches. These aftereffects are compounded by the suddenness of the tragedy, the lack of a discernible cause, and the involvement of the legal system.

Although no postdeath intervention can be expected to completely set aside the difficult challenges associated with a SIDS death, some interventions can help. For example, classification of the death as an instance of SIDS—naming it as an occurrence of a recognizable syndrome—may provide some partial framework for understanding. This diagnosis can help to diminish unrealistic guilt on the part of survivors, who might otherwise have thought they somehow contributed to the death or they could have done something to prevent it. Detailed information about the syndrome and extended support in bereavement can also help SIDS families. Contact with others who have experienced a similar death can be particularly useful.

Surviving children or subsequent siblings should be told in simple, concrete, age-appropriate terms that: the baby's body simply stopped working; the doctors and others who were involved do not know exactly why that occurred; and no one was able to make the baby's body work again. Grief reactions should be acknowledged and modeled, fears and guilt dispelled, and safety and love affirmed.

Helping After a SIDS Death

Many individuals are drawn into SIDS-related events, including first responders, other professionals, relatives, neighbors, and friends. Everyone should focus on listening and observing; offering understanding, practical assistance, and support; avoiding suggestions of blame; and being careful not to make family members feel guilty about the death of their baby. No one should accept at face value statements by distraught parents whose perceived guilt may lead them to unrealistic self-blame for what has happened. Different individuals from different religious or cultural backgrounds may respond in diverse ways to a SIDS death.

At the outset, it is important to assess the situation, initiate life support measures, obtain a history of the events that led to the call for help, and transport the infant to a hospital emergency department. Parents and other family members should be told what is being done and who will provide current and ongoing support. Whenever possible, at least one parent should be allowed to accompany the infant during transport; other transportation should be arranged for those who cannot come along in an ambulance. Arrangements need to be made to care for any involved children and brief explanations provided to them in an age-appropriate manner.

Once death has been pronounced, families will want to know the preliminary cause of death as soon as possible. In the meantime, parents and other family members need a quiet, private place in which to express their grief and be with loved ones. Some will want to help wash and clothe their infant's body. Many will desire to see, hold, or simply be with the infant, often in the company of siblings and other family members.

Helpers should handle the infant's body with sensitivity and respect, while facilitating leave-taking rituals and commemorative or legacy-building activities (e.g., cutting a lock of hair, taking pictures). Most families need information about SIDS, infant death, and loss and grief. Helpers can also

offer assistance in practical matters and arranging ongoing support. As soon as it is available after an autopsy and thorough investigation, families should receive the official postmortem report and have it explained to them.

Everyone who becomes involved in a SIDS death should acknowledge and honor their own reactions to this shocking event, appreciate individual coping strategies, be given access to resources for additional support, and be willing to draw on those resources as needed.

Charles A. Corr

See also Grief, Bereavement, and Mourning in Cross-Cultural Perspective; Infant Mortality; Medical Examiner; Sudden Death

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Suicide

Suicide is most succinctly defined as intentional, self-inflicted death. In addition to fatal behavioral outcomes, of course, a full consideration of suicide also includes those nonfatal, intentional self-harm situations traditionally referred to as suicide attempts, as well as a number of suicidal behaviors and related concepts. The word *suicide* derives from the Latin *suicidium,* a combination of the pronoun for "self" and the verb "to kill." It is suggested that this term was first used in 1651 (although an argument for 1642 has been advanced as well), with a number of phrases utilized throughout history to denote self-initiated deaths. Much discussion of the terms used with respect to suicide and its various dimensions exist. A number of efforts in recent years have taken place to derive a common nomenclature for suicide-related behaviors. It is believed that agreement on the terms used should aid communication about and understanding of the many related concepts. With the coining of the term *suicidology* in the 1960s by Edwin Shneidman for the scientific study of suicide and suicidal behavior, suicide experienced more widespread international attention in research and therapeutic intervention.

While the term *suicide* is of relatively recent origin, existing evidence suggests that suicide has occurred throughout history and across the world. It is clear that suicide has not been a behavior of one time period nor has it been a major characteristic of any one era or location. At least in Western Europe and North America, this long history of suicide and suicidal behavior has often been studied to provide perspective and insights into past and present attitudes, opinions, laws, and behaviors related to suicide. Historical events are noted, often beginning with ancient Greek and Roman philosophers who made arguments either defending (e.g., Seneca, Cicero) or condemning (e.g., Pythagoras, Aristotle, Plato) suicide. Traditional as well as more contemporary viewpoints of major religious beliefs can also be noted, with most groups (e.g., Christianity, Judaism, Islam) strongly opposing suicide, although others are more ambivalent or mixed in their teachings (e.g., Buddhism, Hinduism). In Western Europe and the United States in particular, the main rulings, synods, and councils of the Roman Catholic Church over the centuries established clear and increasing condemnation and sanctions against suicide, most often as a sin. These sanctions included altered or refused burial rights and excommunication. Such religious

backgrounds and the influence of religion on governments produced laws. For example, suicide was a felony in mid-14th century England, resulting in the forfeiture of all land and goods. Suicide remained a crime in British law until 1961.

The superstitions and practices associated with suicide during these periods of time included treatment of the deceased, such as being buried outside sacred ground or even burial at a crossroads at night with a stake driven through the heart. In some cases, bodies were drug through the streets by horses, hung on public display, or thrown in the sewer or a town dump. With the passage of time and different attitudes, particularly the publication of medical considerations of suicide in the mid-1800s, the behaviors shifted away from primarily sin and criminal acts. Instead, suicide became an "insane" behavior. In turn, this interpretation, with its implications of physical and perhaps personality weaknesses or unsound minds, produced feelings of shame and disgrace. Ultimately, with the end of the 19th century and the different thoughts about suicide that emerged in the first half of the 20th century, those who died by suicide or were suicidal were often considered mentally ill. Though much of the shame and stigma remained, religious and social interpretations often held the person less responsible for their actions and many sanctions were relaxed.

The 1897 publication of Émile Durkheim's *Le Suicide* set the stage for the historical events of the 20th century. While not the first book to provide a theoretical interpretation of suicide, it is usually considered, with its statistical methodologies, to be the beginning of what Shneidman would call "suicidology." This theory was followed by others, including the psychoanalytic ideas of Sigmund Freud that contrasted sharply with Durkheim's social forces explanations.

Along with the founding of psychology as a field and its attention to mental disorders and their treatment, the emergence of scientific investigations and the development of psychological therapies for both suicide and depression affected not only the ways in which suicidal behavior was understood, but also the manner in which individuals who were suicidal were treated. Among the most prominent of these treatment-related movements was the founding of suicide prevention and crisis intervention services in both the United States and Europe. These services often took the form of telephone hot lines, typically available 24 hours a day to those who were in suicidal crisis. Eventually, many of these crisis centers and suicide prevention centers offered other services, such as therapy and eventually support groups for those who lost their loved ones to death by suicide.

More recent emphases on physiological explanations of suicide have led to additional interventions, often in the form of widespread use of antidepressants. By the end of the 20th century and the beginning of the 21st century, suicide is most often viewed as a mental health problem, similar to many physical health problems, with lessened condemnation and stigma.

Also advancing the study and treatment of suicidal individuals was the founding of professional organizations that have produced evidence and focus on suicidal behavior over the years. Perhaps most prominent among these were the International Association for Suicide Prevention (founded in 1960), the American Association of Suicidology (1968), the American Foundation for Suicide Prevention (1987), and a community action and advocacy group, Suicide Prevention Action Network USA (1996).

Other historical events that have contributed to these changing attitudes and beliefs, in the United States at least, have been the perspective of suicide as a public health problem. This shift came about primarily by the publication of the Surgeon General's *Call to Action to Prevent Suicide* in 1999 and the subsequent appearance of the *National Strategy for Suicide Prevention* in 2001. This latter document contained many goals and objectives in the national fight to prevent suicide (several countries have adopted similar national strategies). At this time, most states have created state coalitions and groups that have adapted these goals and strategies to their own state efforts. In addition, legislation in recent years has provided federal funds for suicide research and prevention activities, both generally as well as specifically targeted to groups such as the young, the elderly, Native Americans, college students, and veterans.

A long-standing tradition in the study of suicide is the utilization of statistical data derived especially from official national mortality figures. Durkheim established the use of such data to test his theoretical ideas about social factors in suicide.

Individual nations and the World Health Organization regularly compile and disseminate mortality figures and often reports that specifically highlight trends, patterns, and groups at high risk for death by suicide. While the reliability and validity of official data have been questioned in several ways, the figures might be interpreted as imperfect indications of the actual levels of suicide, but at the same time they are likely to represent a conservative estimation. That is, it is likely that no fewer suicides than those officially recorded in death records occur, though there may well be more actual suicides than are officially counted due to such factors as shame, stigma, insurance regulations, and social attitudes. Keeping this perhaps conservative nature of suicide statistics in mind, some idea about the degree to which suicide is an important mental and public health issue can be determined.

Worldwide Incidence of Suicide

Epidemiological data compiled by the World Health Organization suggest that over 1 million suicides take place each year worldwide. Although there are few official data regarding nonfatal suicide attempts, one common estimate is that there are perhaps 25 nonfatal attempts for each death. If this applies worldwide, a figure of 25 million attempts annually would result. For a more complete idea of the full toll of suicide and the lives affected, the number of those bereaved by suicide (see the entry for Suicide Survivors) would also need to be included. Crude estimates place the number of bereaved individuals at no less than six per death by suicide. As the combination of these figures shows, suicide affects large numbers of people annually around the world.

Although suicide exacts a large toll each year, there is tremendous variability across nations in the level of suicide observed. Among the consistent findings in these international figures, it is observed with few exceptions that men are generally several times more likely to kill themselves than are women. Many other demographic variables have been investigated as well. For instance, the world's nations display several patterns of suicide by age, with peak life periods for suicide occurring at young ages in some nations and in late life in others. In addition, seasonal (risk often higher in warmer/spring or summer months), day of week (Mondays usually highest), race and ethnicity (varies by nations), method employed (varies widely worldwide), and geographic regions of nations have also been reported. As an example, in the United States, the highest risk for suicide is observed among Caucasians, the elderly, and men, and are markedly higher in the states of the Rocky Mountain and Southwest region, and more than half the cases use firearms. In the United States as well as some other nations, recent trends in rates (that take into account the number of individuals in the population) have shown decreases for nearly all groups through the 1990s and the mid-2000s.

The previously noted data represent some of the high-risk demographic groups for suicide deaths. There are, as noted, far more nonfatal attempts. In addition, in the case of self-harming, nonfatal behaviors, the groups most often found to be at highest risk differ from those who die as a result of their actions. Studies of nonfatal attempts (referred to also as deliberate self-harm or parasuicides) have demonstrated highest risk among the young and women.

The use of official statistics provides one dimension of high risk for suicide. However, these groups are not the only, or even necessarily the most predictive, with respect to elevated risk. For instance, the strongest relationships between suicide and suicidal behaviors have been observed for psychopathology. Some studies have suggested that as many as 90% of all suicides had some form of mental health condition. Nearly all psychopathologies have been shown to elevate suicide risk, but this is particularly true for mood disorders (especially depression), with substantial but lower risk compared to depression for alcoholism/substance abuse, and schizophrenia. Comorbid conditions are also often noted (e.g., mood disorder and substance abuse). Other high risk factors include past suicide attempts as well as psychosocial factors, such as bereavement, life changes (e.g., job loss or economic difficulties, divorce or separation), family history of suicide and/or psychopathology, and physical illness (especially for the elderly). It is important in the case of all risk factors to realize that the presence of these factors, even several simultaneously, does not ensure that suicidal behavior will occur. Individuals have many forces working to protect them or lessen their likelihood

of suicide or suicidal behaviors, including among them social supports, personality and past behavior, and coping mechanisms. Suicide is not only a complex behavior to predict for individuals, but also demonstrates the multiple factors involved in human behavior.

Theoretical Explanations of Suicide

The multifactorial nature of suicide regarding prediction is mirrored in the theoretical and other explanations of suicide that have been advanced over time. A wide range of forces have been central to the many theories that have emerged, including social, psychological, and biological/medical. At the same time, however, these various explanations of suicide have most often focused on a single domain or issue, seemingly ignoring the obvious multiplicity of factors observed in individual cases of suicide. This resulting focus on single factors or issues has produced relatively distinct theoretical explanations of suicide, but has not, in isolation, increased the ability to predict, effectively treat, or prevent suicidal behavior. The need for integrated theory to explain suicide is apparent but has thus far not been advanced.

In the absence of integrated models, theories suggesting individual issues in the etiology of suicide have influenced therapies and interventions as well as the way in which motivations for suicide have been explained generally. One of the earliest modern theories was Durkheim's sociological theory of suicide. Durkheim advanced four types of suicides that are produced by the social forces of integration (involvement with individuals and social groups) and regulation (influence over the individual by such societal aspects as laws or customs). More than a century later, his concepts of anomic, egoistic, altruistic, and fatalistic suicide continue to influence research and social explanations of suicide. Subsequently, other sociologists have most often tweaked aspects of Durkheim's theory, though some have utilized multivariate statistical methods that include a broader range of social forces.

Early in the 1900s, the first psychological theories of suicide were advanced. Among them were Sigmund Freud's psychoanalytic explanations that centered particularly on the role of depression in suicide, as well as the idea that suicide is the manifestation of aggression and anger toward a loved one that is instead turned inwardly toward the self. Freud also more generally discussed suicide resulting from basic human life and death instincts when death forces overcome those for life. Later, psychological ideas stressed mechanisms such as the personality and traits of the individual, but the most influential psychological theories focused on cognitive and/or learning-related issues. Prominent among these notions have been the importance of helplessness (including learned helplessness), where the individual feels that they are personally unable to effect changes that could alter their lives, and hopelessness, where the individual believes there are no solutions to their problems. These two cognitive sets have often been found in studies of suicidal individuals.

Finally, one of the most influential theoretical efforts to help understand why individuals kill themselves was advanced by Edwin Shneidman. In his most complete model, Shneidman posits 10 commonalities that he observed in the suicidal patients he had treated. While these characteristics included hopelessness-helplessness, frustrated psychological needs, and others, in years following this model Shneidman ultimately argued that "suicide is caused by psychache." Psychache, one of the 10 commonalities, referred to the individual's perception that the psychological pain they were experiencing had reached an intolerable level. This explanation implied a clear clinical prescription for the therapist: to prevent suicide and reduce the individual's pain.

The third basic category of suicide theories involves biological factors. Even relatively early in the history of suicidology, studies of family trees had observed that suicide (like depression) appeared to "run in families." This observation raised the distinct possibility that suicide might be produced by genetic transmission or predispositions. While these studies could not rule out the possible alternative explanations that those who are related biologically often live in the same environments with the same stressors that could increase suicide risk, or that the person who died by suicide might serve as a model for other family members and their subsequent behaviors, the evidence made biology a potential aspect of suicidal acts. Far more widespread than genetic explanations was later research evidence regarding the role of

biochemistry and, more specifically, neurotransmitters associated with depression. The strong relationship of depression to suicide provides an indirect route to suicide through depression.

Intervention With Suicidal Individuals

Individuals who are suicidal have received treatments largely consistent with the theories that have been advanced. In the case of psychological explanations, various forms of psychotherapy (including individual, group, and family) have been utilized widely. Most often in recent years, cognitive and cognitive-behavioral approaches have been employed to confront and eliminate the several potential cognitions and behaviors of the suicidal individual that lead them to suicidal ideation and acts. One particularly effective treatment is Dialectical Behavioral Therapy, developed by Marsha Linehan. This therapy focuses on psychosocial forces in suicide, specifically targeting not only suicidal and injurious behavior but also behaviors that interfere with treatment and the individual's life. In addition to these largely psychological therapeutic approaches, biological and especially biochemical factors in suicide and depression have led to widespread prescription and use of antidepressant medications (not without controversy, however, including evidence that some antidepressants may actually increase suicide risk in some patients or categories of patients). Recent evidence has found that the most effective treatment of depression (with the associated lessening of suicidal behavior) is observed when there is a combination of psychotherapy and antidepressant medications rather than either one alone.

Therapeutic intervention is not the only avenue for suicide prevention. At least since the 1960s, suicidologists have attempted to educate individuals, from gatekeepers who frequently come into contact with the suicidal to the general public, about how to recognize those who are suicidal and how to get help for them. This public education has centered on the delineation of clues or warning signs that are exhibited by those contemplating suicide, as well as the circumstances and factors associated with high suicide risk. In all cases, however, one of the basic measures to take if warning signs are observed is to seek professional help immediately. In addition to mental health professionals in the community, another source of assistance available in a large number of communities is found in crisis intervention or suicide prevention centers noted earlier. The public health approach to suicide stresses prevention measures at several levels, with such efforts as teaching coping mechanisms at young ages to method restriction measures.

Finally, ethical discussions of suicide are not new. Philosophers and others have advanced ideas about the right to and the morality of suicide throughout time, as well as the ability to make a rational decision to die. In the late 20th century and the start of the 21st century, these discussions have emerged as more than academic exercises. Legislation regulating, and in some cases providing for suicide, have resulted from and have produced subsequent social and cultural battles. At a point in time when suicide prevention and treatment efforts are at their most widespread, the arguments defending and making suicide available as an option have taken place on several fronts. Books were published in several nations that provided specific information about how to kill oneself. A physician, Jack Kevorkian, assisted over 100 individuals before being convicted for his assistance to an individual he helped die. Laws and their enforcement have led to the availability of assisted suicide in some nations, such as the Netherlands, and Oregon in the United States, and permit assisted suicide under certain conditions. Self-inflicted intentional deaths continue to be viewed by some as an option to hasten death, while in the larger community, and especially in the mental health arena, the prevalent viewpoint seems to be that death by suicide is unnecessary, and it can be and most often should be prevented.

John L. McIntosh

See also Assisted Suicide; Psychache; Suicide Survivors

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Suicide, Counseling and Prevention

The term *suicide* encompasses both behaviors in which people intentionally cause their own deaths (complete suicide or fatal suicide) and those behaviors where the person survives the action (attempted suicide, parasuicide, or deliberate self-harm). Suicidal behavior, more than many other behaviors, often creates severe anxiety in those professionals who encounter and endeavor to help such individuals because of the fear that the smallest misstep may result in their clients' deaths.

Overview

There are six major tactics that have been employed for preventing suicide:

1. *Preventing access to lethal methods of suicide*. Preventing access to lethal methods of suicide includes such tactics as fencing in high bridges and buildings to prevent people jumping from them, passing and enforcing stricter gun control laws, and using less toxic and lethal medications for psychiatrically disturbed individuals. It is impossible, of course, to limit access to all methods for suicide. For example, drowning, hanging, and cutting are available to most individuals. Furthermore, it is likely than many, although not all, individuals will switch methods for suicide if their preferred method is unavailable. However, this tactic may delay the suicidal action and provide an opportunity for crisis intervention.

2. *Educating people about suicide and the resources available for suicidal individuals*. These programs have been primarily set up in schools where the students are given information about suicide and the community resources available, and sometimes, basic information about crisis intervention. There is research that indicates that these programs do inform students about suicide and resources, but there is no evidence yet on whether they indeed prevent suicide.

3. *Educating general practitioners*. In some regions of England, Hungary, and Sweden, educational programs have been established to educate general practitioners and family doctors on the identification of and appropriate medications for the depressed patients that they encounter in the course of their practice. The available evidence to date indicates that these programs may, in some cases, result in a temporary reduction in the incidence of suicide in some segments of the population (for example, women).

4. *Crisis intervention hot lines and walk-in clinics*. Telephone crisis intervention centers have been set up in many nations of the world, some of which have walk-in clinics with around-the-clock access so that suicidal individuals can receive crisis intervention. Some nations have now established toll-free numbers that serve the whole nation, and crisis intervention is now available online via e-mail and instant messaging.

5. *Programs for survivors*. Survivors are those who have had a loved one or significant other commit suicide. Research has shown that this type of loss increases the potential for suicide in the survivors, and self-help groups are available in many nations for survivors (see the websites mentioned earlier). Protocols have also been established for helping people after friends, peers, or fellow staff members have committed suicide.

6. *Providing treatment for suicidal individuals*. Once suicidal individuals have been identified or

have sought help on their own initiative, they can be provided with effective treatment involving both medication and psychotherapy. These are addressed in the following sections.

Medication for Suicidal Individuals

The primary tactic for helping suicidal individuals is to identify their psychiatric disorder and prescribe the appropriate medication. If the suicidal individual has schizophrenia, then an anti-psychotic medication is needed; if they are anxious, an anxiolytic agent is needed; and if they are depressed, either an antidepressant or a mood stabilizer (for bipolar affective disorders) is needed. There is a great deal of research on the effectiveness of these medications, with clear evidence-based data.

For example, there is good evidence that clozapine reduces subsequent suicidal behavior in schizophrenic patients, although it may increase mortality from cardiovascular side effects. Most suicidal individuals are depressed, and the majority of these are diagnosable as depressive disorder for which antidepressants are useful. In recent years, countries such as Hungary and Sweden have witnessed a tremendous increase in the recognition and medication of depressed individuals, and this has been accompanied by a decline in the suicide rates of these nations. However, not all nations have witnessed this decline in suicide rates as antidepressants became more widely used. Furthermore, there have been claims that the use of selective serotonin reuptake inhibitors (SSRIs) for depression does, in rare cases, increase the potential for suicide. This has led to warnings to physicians that the SSRIs are not suitable for children and adolescents without very careful monitoring. However, the mortality rate (from accidental overdoses and suicide) is much less for the SSRIs than for the older antidepressants. A recent analysis of data from 26 countries for up to 25 years estimated that an increase in SSRI sales of one pill per capita (a 12% increase over 2000 sales levels) would result in a 5% decline in deaths from suicide.

Lithium maintenance therapy has long been used to treat patients with bipolar disorders (commonly known as manic-depressive disorder), and there is good evidence to show that it reduces the risk of suicide in these patients. In addition, recent research indicates that lithium may be useful in reducing suicide behavior for patients with any type of affective disorder.

Psychotherapy

While the typical treatment that suicidal individuals receive (for example, after emergency room visits) does not seem to have proven effective in preventing later suicidal behavior, there is some evidence that focused counseling may be beneficial. Although all of the major systems of psychotherapy have been applied to suicidal clients, two systems are especially useful—crisis intervention and cognitive therapy.

Crisis Intervention

Crisis intervention was first applied to counseling suicidal clients when telephone hot lines were established in the 1960s. Most communities in the developed world have access to a local or national telephone service that provides crisis counseling for suicidal individuals. The crisis counselors are typically volunteer paraprofessionals who have been trained in crisis intervention.

The first step is "active listening," the popular term for the person-centered counseling developed by Carl Rogers. The next step is the assessment of the person's resources, both personal strengths and social supports. Finally, the counselor helps the client devise one plan of action, even if it is a small step, and the client is encouraged to carry out this plan and to call back to let the center know whether the plan helped the client. Now that crisis intervention for suicidal clients has moved to the Internet, the first step in crisis counseling has required modification because e-mailing requires more substantial responses on the part of the crisis counselor than person-centered therapy typically entails.

There has been some research on the usefulness of specific types of responding by crisis counselors for positive short-term outcomes and documentation that suicide prevention centers may have a weak, although statistically significant, impact on the societal suicide rate. But the overall usefulness of crisis counseling for preventing suicidal behavior does not yet meet the criteria for evidence-based treatment.

Cognitive Therapy

The use of cognitive therapy for suicidal clients was stimulated by the research in the 1960s documenting dichotomous and rigid thinking in suicidal individuals. Because cognitive therapy is a short-term psychotherapy focused on changing the irrational thinking of clients, and because suicidal individuals usually show irrational thinking, cognitive therapy is useful for dealing with suicidal clients. Building on the rational-emotive therapy, cognitive-behavioral therapy was first successfully applied to depressed and anxious clients. Since that initial success, the cognitive-behavioral therapy and other variants of cognitive therapy have also been used successfully with suicidal clients.

Dialectical behavior therapy (DBT) was developed to treat borderline personality disorder, but DBT has also been successfully used with suicidal clients. DBT is a cognitive behavior therapy with additional components, and the manuals and books describing DBT present a complete systematic guide for conducting psychotherapy, with a special focus on the problems presented by clients with borderline personality disorder. In addition to a cognitive-behavioral approach, DBT focuses on the dialectic involved (accepting and validating clients' behavior while insisting that they change) and on some Zen Buddhist meditation techniques (to encourage mindfulness), which help clients learn to observe and describe, be nonjudgmental, and focus on the present. DBT takes a minimum of a year, and employs two counselors holding separate sessions with each client.

Other Systems

Several other systems have also explored their use for suicidal clients. Voice therapy, a system of counseling that addresses the early trauma that characterize the lives of suicidal clients, and the defenses that suicidal individuals develop, in particular the voice process, a well-integrated, discrete antiself system that appears as intrusive self-deprecating thoughts in the individual's mind. The psychotherapist helps the individual to recognize and express this voice so that the psychotherapist can assist the client in challenging it.

Mental health professionals do not always agree that suicide is always an inappropriate choice. Under certain circumstances, such as extreme physical or psychological pain, suicide may be viewed as a rational and appropriate decision. There are websites that provide information on how to choose an appropriate method for committing suicide, and there are books helping people make a good decision about this option. Finally, some countries, such as the Netherlands, and some states, such as Oregon in the United States, also have established procedures to follow for those who want assistance in committing suicide.

David Lester

See also Assisted Suicide; Mass Suicide; Right-to-Die Movement; Suicide; Suicide, Cross-Cultural Perspectives; Suicide Survivors

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Suicide, Cross-Cultural Perspectives

An estimated 850,000 to 1 million people worldwide died by their own hand during the year 2000. Although a worldwide average rate of suicide is not available because of the unevenness of reporting, the World Health Organization offers that for every act of successful suicide there are approximately 10 to 20 unsuccessful attempts. In terms of the human condition, for every suicide there are surviving family members and significant others whose lives are profoundly affected

emotionally, economically, and socially. These issues are addressed herein.

Worldwide data that are available indicate suicide ranks as the 13th leading cause of death and is generally ranked in the top 10 leading causes of death in the more developed nations. Indeed, in the developing countries of the world, suicide has increased more than 60% since 1960. This problem is particularly acute for India and China, which currently record the highest rates of suicide, 98 and 99 per 100,000 people, respectively. Along with Japan, India and China are thought to account for up to 40% of the total number of suicides recorded each year.

Among the young, ages 15 to 44, suicide ranks as the 4th leading cause of death worldwide. Unlike other leading causes of death, including heart disease and cancer, suicides are preventable. Suicide victims die at an earlier age than cancer or heart disease decadents; the modal age for suicide in the United States is currently a 44-year-old male with no life-threatening diseases. Hence, the years of potential life lost in the case of suicide deaths is much greater per death than for the most common causes of death.

The suicide rates (per 100,000 population) of the world's nations show considerable variation. In the year 2000, for example, suicide rates were as low as 5.5 per 100,000 for males in Greece and included rates many times greater such as 50.7 per 100,000 in Hungary. For females during that same year, the rate of suicide ranged from 1.5 per 100,000 in Costa Rica and Greece to a high of 15.1 per 100,000 in Hungary. The highest rates are generally found in Eastern Europe and the lowest rates in Latin America and Muslim nations. Suicide rates also tend to increase with age, and are higher among men than women. Given the statistics noted previously, this entry is organized around five features of society that increase the risk of suicide. These risk factors include gender, modernization, marital disruption, economic strain, and the "culture of suicide."

Gender Roles and Gender Role Change

One of the most well-documented social facts in comparative suicide studies is that men have a higher suicide rate than women. In the developed nations, for example, the male suicide rate is generally at least twice that of females. In the United States, the ratio is currently 4.3, in Austria 2.8, France 2.9, and Sweden 2.5. Reasons for this gender differential are not fully understood. Common explanations include (a) religiosity levels, a protective factor against suicide, are higher among women than men; (b) a key risk factor for suicide, alcoholism, is five times higher among men than women; (c) greater help-seeking behavior for mental health problems among females than males, both for professional help as well as help from support networks; (d) women have stronger negative attitudes toward suicide than do men; and (e) women have less access to and less knowledge about firearms, a highly lethal means of suicide, than do men.

However, the ratio in male to female suicide rates has changed over time. For a sample of more developed nations, during the period 1919 to 1972, as levels of economic development increased, there was a decline in the male to female ratio in 16 of 17 countries. This was a period marked by substantial increases in women's labor force participation rates. Further, women often faced a "double shift of work" characterized by paid work in the labor force during the day and long hours of housework and child care during the evening and weekends. Conflict between the script roles of paid work careers, motherhood, and homemaker were thought to contribute to an increasing suicide risk for women.

However, in most developed nations the convergence in gender suicide rates reversed in the 1970s. Female rates started to go down and/or male rates increased faster than female rates. In the United States, for example, the ratio converged to 2.6 by 1970, but diverged to 4.3 by the year 2000. This was mainly due to a fall in the female suicide rate from 6.3 to 4.3 per 100,000.

During this same time period, a critical mass of women entered the labor force and cultural definitions of female and male roles changed. Defining the working mother in more positive terms, new social arrangements emerged intended to address the dual roles of work and home, including widespread use of day care centers and greater male participation in household work and child rearing. And as women achieved substantial gains in the labor force, male dominance of the more prominent occupational positions declined. But instead of declining, male suicide rates increased.

A similar analysis focusing on 18 developed nations reported male and female suicide trends during the years 1953 to 1992 lent similar support for a curvilinear argument. A period of convergence in the gender ratio in suicide was followed by a period of divergence beginning in the 1970s, with male rates increasing disproportionately to female rates. Institutional adjustments to gender role change in late modernization protect women from suicide more than men. In Australia, another highly developed nation, the gender suicide ratio diverged from 2.2 to 3.8 between 1970 and 2000. As shown in Table 1, male rates increased while female rates decreased over this 30-year period.

Suicide and the Modernization Process

A leading predictor of the wide variation in suicide rates among nations is the level of modernization. Modernization comprises three interrelated dimensions: economic development, urbanization, and secularization. Each tends to break down the ties between the individual and society. Migration from the countryside to urban centers erodes ties to ancestral farmland, friends, and kin. Industrialization, driven by specialization or occupational differentiation and efficiency, requires mass education. Education, however, contributes to critical thinking, questioning, and a weakening of religious faith. Industrialization thrives on a large mass of consumers. Religiosity is weakened, while a value of consumer items and materialism are strengthened. In traditional agricultural culture, where most people had the same occupation of farmer, dogmatically shared the same unquestioned religious beliefs, and had ties to ancestral small villages, this was replaced by an ever-changing, questioned, and diverse culture and social order wrought by industrialization.

In addition, a culture of tolerance is fostered by the financial security of industrialization. Widespread poverty, famine, drought, epidemics, and other calamities are eliminated or brought under control by modern medicine and technology. In analyses of people in over 80 nations, it has been determined that financially secure populations in the more developed nations are more apt to be tolerant of other ethnic groups, political opponents, religious differences, and a host of formerly forbidden deviant behaviors, including divorce, homosexuality, and suicide.

The most widely studied aspect of modernization in suicide studies is level of economic development. The notion that the greater the economic development, the greater the suicide rate has been supported by a large number of cross-sectional comparative studies. However, choosing suicide over life is thought to stabilize or even decline at advanced levels of modernization. After the initial shock of rural to urban migration, and people adjust to living in a largely secular social order, suicide rates may decline. An analysis of Finland during the years 1749 to 1900 (the oldest set of suicide data) found that a 1% increase in urbanization was associated with a .22 increase in suicide rates from 1749 to 1900. However, from 1900 to 1985, a 1% rise in urbanization was associated with just a .12% rise in suicide rates. Further, as the data in Table 1 suggest, Finland's male suicide rate stabilized at 34 per 100,000 people between 1970 and 2000. But many nations are currently in the process of modernization, and their suicide rates would be expected to increase. For example, in Table 1, suicide rates increased between 1970 and 2000 in many developing nations, including Costa Rica (4.1 to 10.7 per 10,000), Mexico (1.8 to 6.0), Panama (5.3 to 8.4), and Thailand (5.0 to 13.5).

Some variation in the modern suicide rates is mediated by culture zones. One assessment of annual suicide trends in 20 advanced European nations from 1900 to 1972 found that no clear relationship existed between modernization data and annual suicide rates. Suicide rates increased in one-third of developed nations, decreased in one-third, and remained relatively constant in a third. Predominantly Catholic nations, a culture zone incompatible with modernization, tended to fall into the first group. Protestant nations, with values more compatible with industrialization, comprised the second group. Nations with a mixed religious system constituted the third group.

More recent suicide rate trends in developed nations tend to confirm this pattern. The male suicide rate in Catholic Ireland increased from 3.0 to 20.3, the male rate in Protestant Sweden decreased from 31.3 to 18.3, and the male rate in religiously mixed Switzerland stayed essentially the same (27.4 to 27.8) during the 1970 to 2000 period.

Table 1 Male and Female Suicide Rates (per 100,000 Males and 100,000 Females) in Selected Nations, 1970 and 2000

Nation	*Male, 1970*	*Female, 1970*	*Male, 2000*	*Female, 2000*
Australia	17.0	7.6	19.8	5.2
Austria	35.5	14.2	29.3	10.4
Bulgaria	16.1	7.7	25.2	9.1
Canada	16.2	6.4	18.4	5.2
Costa Rica	4.1	0.6	10.7	1.5
Czechoslovakia	37.5	13.6	26.0	6.7
Denmark	27.4	15.7	21.4	7.4
El Salvador	12.6	1.6	11.6	5.4
Finland	34.4	9.2	34.6	10.9
France	22.8	8.4	27.9	9.5
Germany–East	40.4	22.0	na	na
Germany–West	28.2	15.0	na	na
Germany–combined			20.3	7.0
Greece	4.6	1.8	5.5	1.5
Hungary	50.8	19.8	50.7	15.1
Ireland	3.0	0.5	20.3	4.3
Israel	6.9	4.6	9.8	2.3
Italy	8.1	3.5	10.9	3.5
Japan	17.2	13.2	35.2	13.4
Mauritius	2.9	0.5	18.8	5.2
Mexico	1.8	0.5	6.0	1.1
Netherlands	9.9	6.2	12.7	6.2
New Zealand	12.6	6.6	19.8	4.2
Norway	11.8	5.0	18.5	5.8
Panama	5.3	0.9	8.4	1.3
Poland	18.8	4.0	25.9	4.9
Portugal	11.9	3.4	8.5	2.0
Singapore	10.6	7.1	12.5	6.4
Spain	6.9	2.1	13.1	4.0
Sweden	31.3	13.2	18.3	7.3
Switzerland	27.4	10.1	27.8	10.8
Thailand	5.0	3.4	13.5	3.7
U.K.–England & Wales	9.5	6.6	10.2	3.0
U.K.–N. Ireland	4.7	3.2	15.6	3.8
U.K.–Scotland	9.5	6.0	21.1	5.2
USA	16.1	6.3	17.1	4.0
Venezuela	9.5	4.0	8.8	1.5

Sources: World Health Organization, *World Health Statistics Annual, 1970*, and http://www.who.int/healthinfo/morttables/en/print.html.

Marital Disruption

Supportive family structures protect against suicide. Conversely, as families are disrupted by divorce and widowhood, suicide risk increases. Loss of a spouse is often marked by social isolation, depression, and economic hardships, all of which contribute to suicide. In the United States, divorced people have a depression level that is 40% higher than their married counterparts. A review of 132 studies containing 789 findings from 1880 to 1995 determined that divorce and divorce rates tend to be predictive of suicide risk.

Divorced people are typically at greater risk of suicide than married people. In a review of a century of research, a total of 426 of 493 findings (86.4%) determined that divorced people had higher suicide rates than married people. In Austria, divorced people have a suicide rate of 128.6, compared to 30.5 per 100,000 for their married counterparts. A coefficient of aggravation (COA) divides the suicide rate of the divorced by that of the married. The COAs for divorced men versus married men were 4.42 in Australia, 6.18 in Denmark, 4.24 in Finland, 2.21 in France, 5.08 in West Germany, 3.57 in Italy, 5.09 in the Netherlands, 3.59 in Norway, 3.79 in Sweden, 4.54 in Switzerland, 3.72 in the United Kingdom, England, and Wales, and 4.17 in the United States. For females, the COAs were 4.05 in Australia, 4.55 in Denmark, 2.94 in Finland, 1.93 in France, 3.08 in West Germany, 17.0 in Italy, 3.56 in the Netherlands, 2.86 in Norway, 3.35 in Sweden, 3.4 in Switzerland, 2.61 in the United Kingdom, England, and Wales, and 3.22 in the United States. With the exception of Italy, divorce is a stronger risk factor for suicide in the case of males than for females. Nevertheless, divorce substantially raises the risk of suicide for women as well as men in all nations for which data are available. In most nations, divorced people have a suicide rate three to four times greater than married people of the same age.

Economic Strain

The rate of suicide among the unemployed varies across nations. This fact corresponds to the size and duration of the economic safety net for the unemployed that vary from nation to nation to include unemployment programs and the size of and duration of unemployment benefits. There is substantial evidence that the unemployed have a higher suicide rate than their counterparts, including age-matched working peers. Recent research in England determined that the unemployed had a suicide rate of 20.5 per 100,000, compared to 10.3 for the general population. In Austria, the relevant rates were 93.3 versus 25.0 per 100,000; and in Italy, 3.2 versus 2.1 per 100,000. And a study of 9,011 suicides and 180,220 living controls in Denmark determined that unemployment raised the odds of suicide between 1.69 and 2.38 times. A New Zealand study determined that unemployed males were 2.7 times more apt to die by suicide than employed men. Unemployed females were 2.86 times more likely to commit suicide than their age matched peers. In the United States, a longitudinal study determined that unemployed males were 2.3 times more apt to die by suicide than employed men. And in investigations that control for psychiatric morbidity, such as depression level, unemployed males were found to be at greater risk of suicide than employed males.

Socioeconomic Status (SES)

Specialized high status groups, such as physicians, have high suicide rates. However, in general the results have been highly consistent: the greater the socioeconomic status (SES) of groups, the lower their suicide rates. That lower status groups should have higher suicide rates would be expected because they tend to have higher risk factor rates, including unemployment, divorce and desertion, morbidity, severe mental disorders, and crime victimization.

A variety of measures of socioeconomic status are used to assess the relationship between SES and suicide risk. In a New Zealand cohort study, men with household incomes of less than $20,000 were 2.22 times more apt to die as a result of suicide than men with household incomes of greater than $50,000. For women, the corresponding risk ratio was 2.0 times as great as that of males. Recent English data, for example, shows a rate of 46 per 100,000 for unskilled workers, more than 3 times the rate for professional workers (13 per 100,000). In Australia, the suicide rate for all manual workers (skilled and unskilled combined) was 32.5 per 100,000, compared with a suicide rate of 20.5 per 100,000 for professional and managerial workers

combined. U.S. laborers have a suicide rate of 94 per 100,000, more than 8 times the national average. One U.S. study employed a composite index of income, occupation, and other dimensions of status to divide the population into four socioeconomic status groups. Males in the bottom quarter in SES had a suicide rate of 42.2 compared to 18.6 per 100,000 for men in the top quarter. For females these rates were 7.2 versus 5.8 per 100,000.

The Culture of Suicide

The most recent development in comparative analysis of national suicide rates involves the influence of public opinion or the degree of approval of suicide. Research samples of 19 to 35 nations links the degree of public approval of suicide to national suicide rates; that is, the greater the public approval of suicide, the higher the suicide rate. American research has often linked the degree of suicide acceptability in individuals to their relative risks of suicide attempts and suicide completions. Public approval of suicide in the case of a terminal illness, bankruptcy, being tired of living, and dishonor of family are also measured in world values surveys. In addition, the U.S. general social surveys conducted during 1972 to 2006 measure suicide acceptability. The results tend to demonstrate a positive relationship between high cultural approval of suicide and high suicide rates.

In Table 2, the data refer to the question "Is suicide when one is incurably sick never justified, always justified, or somewhere in between?" On a scale from 1 to 10, the average acceptability score for these worldwide data is 4.11. Suicide approval scores ranged from a low of 2.39 in Poland and 2.57 in Catholic Ireland, to 6.82 in China and 6.14 in Finland. This measure is also reported to be highly correlated with other measures of suicide acceptability in the world values survey.

Table 2 Mean Scores Approval of Suicide in the Case of a Person Who Is Incurably Sick*

Nation	*Mean Suicide Approval*	*Nation*	*Mean Suicide Approval*
Austria	3.76	Japan	5.46
Argentina	2.72	Latvia	4.06
Belgium	4.92	Mexico	3.99
Brazil	2.66	Netherlands	5.98
Britain	4.67	Nigeria	3.28
Bulgaria	3.60	Northern Ireland	3.40
Canada	4.98	Norway	4.24
Chile	2.70	Poland	2.39
China	6.82	Portugal	3.11
Denmark	5.60	Romania	3.57
East Germany	3.97	Russia	3.70
Finland	6.14	Slovenia	4.06
France	5.22	Spain	4.23
Hungary	4.37	Sweden	5.07
Iceland	4.67	Turkey	3.23
India	3.31	USA	4.17
Ireland	2.57	West Germany	4.10
Italy	3.80	**All Nations**	**4.11**

* where 1 = never justified, 10 = always justified.

Source: World Values Surveys and European Values Surveys by R. Inglehart, 2000, Ann Arbor, MI: Inter University Consortium for Political and Social Research.

In sum, there are many risk and protective factors for suicide. The risks include psychiatric factors, such as depression, manic depression, and schizophrenia; the availability of firearms; exposure to mass media stories and films concerning suicide; and biological factors, such as low serotonin. Protective factors are better known as the factors that constitute the strength of the social bond first discussed by Émile Durkheim. Although the risk factors have not been subject to rigorous comparative research, this void represents a fertile opportunity for future cross-national investigation.

Steven Stack

See also Discretionary Death; Social Class and Death; Suicide; Suicide Survivors

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Suicide Survivors

Survivor of suicide does not refer to individuals who have made a nonfatal attempt on their life. Rather, a survivor of suicide is a loved one or other individual who has experienced the death by suicide of someone close to them. The less ambiguous wording "bereaved of suicide" is used in Australia. The term *survivor of suicide*, therefore, is appropriate in the context of the aftermath of a suicide death. The sequelae of suicide may include a difficult and complicated bereavement experience. Edwin Shneidman, founder of the American Association of Suicidology, expressed his belief that the greatest mental health toll associated with suicide occurs among the survivors of suicide. Despite this contention, the topic of suicide survivors remains one of the most neglected areas in suicidology.

Although relatively little research exists regarding suicide survivorship, available evidence provides initial insights of suicide survivorship. Virtually no epidemiological data have been gathered regarding how many individuals are survivors or their characteristics. It is usually suggested (though not based on epidemiological investigation) that there are at least six survivors for every suicide. If true, the 32,000-plus annual U.S. suicides produce more than 190,000 survivors each year. As one measure of the cumulative effect, the more than 750,000 suicides in the last 25 years would be associated with over 4.5 million survivors, or at least 1 of every 65 Americans (1.5%). One small-scale study implied 5.5% were survivors. Even using conservative estimates, the number of surviving family members and friends is substantial.

The impact of suicide on survivors' grief and bereavement has yet to be adequately studied. Personal accounts and research have provided delineation of some characteristic aspects of suicide bereavement. While potentially unique features may result from experiencing the suicide of a loved one, it is important before considering these to understand that suicide survivors share aspects of grief common to essentially all bereaved individuals. For instance, as with other deaths, the suicide grief process is unique and individual, it follows no time frame or specific duration, and its movement is not always in a forward direction.

Many specific characteristics of grief following death by suicide have been described in the past 35 years. University of Michigan professor Albert Cain produced one of the earliest considerations of the topic in the 1972 edited book, *Survivors of*

Suicide. Cain's book provided a portrayal of the reactions and features of suicide bereavement largely from clinical case descriptions. Many of these reactions would later be observed in studies and survivors' accounts of their personal journeys following suicide loss. Cain's volume noted the bereavement reactions of guilt, rage, search for meaning associated with the death, identification with the person who died by suicide, incomplete mourning, as well as depression and self-destructive behaviors among the bereaved. Additionally, anniversary reactions, feelings of shame, stigma, abandonment, and preoccupation with the topic of suicide and suicide prevention efforts were listed. Although these published descriptions were available, a 1982 review by Lawrence Calhoun and his colleagues from North Carolina revealed a number of published studies of survivors, but also a particularly problematic issue. Specifically, among several methodological difficulties, not a single investigation had included a group of survivors of other modes of death to which suicide survivors of the study could be compared. Therefore, any attempt to specify unique grief features or differences among suicide survivors was impossible. As a result, Calhoun and colleagues were willing to venture only "cautious generalizations" derived from the sheer consistency of the themes could be offered. Perhaps three commonalities for suicide bereaved as compared to other bereaved individuals can be derived from this work. They suggested that suicide grief may differ from other causes in the prominence of feelings of guilt, a search by suicide survivors to understand their loved one's death, and lower amounts of social support following the death.

Following this important review, the number of studies slowly increased, with many including comparison groups and often other improved methodological characteristics. In 1993, John McIntosh, coeditor of a 1987 professional book on survivors, reviewed the modest control group literature and drew several conclusions about suicide grief. His conclusions were (a) though often intense, delayed, and complex, suicide bereavement is generally nonpathological; (b) current research supports more similarities than differences between individuals bereaved of suicide and other modes of death, particularly with accidental death survivors; (c) while a small number of grief reactions or characteristics of suicide grief possibly differ from other modes of death and may comprise a "survivor syndrome," the current research findings are inadequate to demonstrate the precise differences and the uniqueness of specific characteristics; (d) the course of bereavement over time following suicide may differ from that of other survivors, but (e) by some time after 2 years, grief differences are minimal or not apparent; and (f) the variables of kinship to the deceased, the quality and closeness of the relationship to the deceased, and the time that has passed since the death appear to be important factors in the suicide bereavement process.

These conclusions are not shared by all, particularly the suggestion that, though possibly existing, there is insufficient evidence for specific differences. Others have argued that present evidence is strong enough to support some suicide bereavement differences. One such author, Jack Jordan, a therapist who has written extensively on survivors, emphasized the strength of qualitative evidence to support three themes for suicide grief. Jordan identified these themes as feelings of guilt and associated experiences (i.e., shame, responsibility, blaming), attempts to find meaning in their loved one's death, and feeling rejected and abandoned by and feeling anger toward the deceased. Other writers have criticized the focus on generalizations with the possible concern that the tremendous individuality of suicide survivors' grief experiences will be overlooked.

Among several issues with respect to current survivors research, one of the most consistently apparent factors that affect grief and bereavement is the relation of the survivor to the deceased. This includes the kinship of the survivor to the deceased, as well as the nature of their relationship. The number of survivors studies has increased slowly over time. However, these studies most often compare survivors of suicide and other causes who shared the same kinship relation to the deceased and are not comparisons of general samples of survivors of suicide and other causes of death (i.e., representing a range of kinship relations to the deceased). Although inadequate studies have been conducted of any relationship category, the majority of studies are of a few kinship relations. These investigations have yielded some general issues. The most studied relationship group has been parents who have lost a child by suicide. These studies have shown guilt and related aspects (i.e., shame and stigma) as perhaps the most prominently

reported aspect of parent survivors' grief. The small literature on attitudes toward survivors has shown that parents are blamed and held responsible for their child's death, and they are liked less than parents whose child died by other means. Thus, parents feel responsible and guilty, and society seems to feel this way as well. Although personal accounts by parents often note a lack of support received from others following their child's death by suicide, research findings, including comparative groups, are equivocal. In the case of a child's death, both positive and negative outcomes in overall family adaptation have been noted, though parents surviving a suicide death may more often experience negative adaptation both in their family relationship and that with the other parent.

Spouse survivors are another frequently studied kinship relation, and nearly all of these studies involve widows. These studies are among those most likely to have observed more similarities than differences for spouses bereaved of various modes of death, particularly comparing suicide and accidental deaths. Spouse survivor studies often observed bereavement group differences, but little consistency in the particular grief aspects that differ emerged. A third group for which several studies have been conducted is children who are survivors of a parent's suicide. It should be noted that many of these studies have been conducted with an emphasis on mental health issues (as compared to a focus on grief and bereavement per se). Thus, studies of children who are parent suicide survivors have commonly observed that they are vulnerable and at high risk for mental health symptoms. With respect to bereavement, children have shown feelings of guilt for their parent's death and identification with the deceased parent. A special circumstance for this group of survivors was the often misleading or even false information provided to them by other family members, apparently in an attempt to protect them. This may include the mode of death, details of the death, or other aspects. The majority of these studies have included those who were young at the time of their parent's death (i.e., they were children at that time). Recent encouragement has also emerged for investigations of adult children who survive their parent's suicide.

While a small number of studies have been conducted with sibling survivors and therapists who have lost a client to suicide, the majority of kinship and other relationship categories in people's lives have not been investigated. Survivors are not exclusively those with family/blood/biological relationships. Interestingly, research by the Baton Rouge Crisis Intervention Center in Louisiana observed that individuals with 28 different relationships to the deceased sought and attended their formal suicide grief support groups.

Suicide postvention refers to the issues of treatment in the aftermath of suicide. Many communities provide general bereavement resources and sometimes separate resources for suicide survivors, usually in the form of support groups. Support groups may follow a variety of models, but typically the sharing of common loss experiences is a major aspect of the group. Survivors are able to realize they are not alone in their loss, that others feel or have felt the same way they do, and survivors further along in their grieving process provide hope and help to the new survivor as they attempt to heal from their own loss. Although not yet investigated, the personal experience literature clearly indicates that suicide survivors believe they benefit most from homogenous-loss support groups. That is, they believe they are most helped by support groups comprised exclusively of others who have lost someone to death by suicide rather than a mixed group of those who are grieving the loss of loved ones from various modes of death. In addition to support groups, some suicide survivors seek or receive individual as well as family therapy.

A final issue is survivors' contribution to suicide prevention and postvention. As noted, survivors have often been observed to seek understanding of and to make meaning from their loss. They also wish to spare others the pain they experienced following a loved one's suicide. In addressing these issues, survivors have shared their experiences in first-hand accounts; they have developed, participated in, and facilitated survivor support groups; and many have worked to raise public awareness and advocate for suicide prevention and survivors. A primary reason for the growth in attention to survivors has been the involvement and determination of survivors themselves to increase focus on this aspect of suicidal behavior. This has benefited survivors and the study and treatment of suicidal individuals as well. Consistent with Edwin Shneidman's characterization, this largest mental

health casualty area deserves greater research and clinical attention, not only to increase our understanding of the aftermath of suicide, but most importantly, to assist survivors' efforts to confront and heal from their loss.

John L. McIntosh

See also Bereavement, Grief, and Mourning; Euthanasia; Grief and Bereavement Counseling; Suicide; Suicide, Counseling and Prevention

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Suicide survivor support group listings: http://www.suicidology.org and http://www.afsp.org

Survivor Guilt

Survivor guilt is the term used to identify feelings of responsibility and self-blame in those who experience the death or significant loss of someone that they care about and wonder why they were spared. It is a common theme in literature and entertainment media and is seen both in response to individual losses and to catastrophic events in which many people are killed or injured, such as the Nazi Holocaust. Survivor guilt can be classified into two types: the first is existential survivor guilt. In this type, survivor guilt is frequently part of the post-traumatic stress disorder seen in soldiers who survive the roadside bomb that kills others in their armored vehicle. In such cases, the person is literally left behind when others have died. Survivor guilt is found not just in the survival of the death of others but in the guilt associated with how one escaped from difficult, life-threatening circumstances. The second type is content survivor guilt. In content survivor guilt, the focus is not only on surviving, but on what one did to survive. In either form, survivor guilt is a deviation from the question: "Why me?" to the question "Why not me?" Both questions arise from the same existential attempt to find meaning and re-establish a sense of control over events and circumstances outside of human control. This entry will describe survivor guilt as a form of grief, as well as discuss some of the ways to support those who experience it.

Guilt and Grief

Virtually every author who writes about loss and grief mentions guilt as one of the feelings experienced by those who are bereaved. In some cases, it is associated with an exaggerated grief response, typically that of depression. Guilt in survivors is seen as a part of the anxiety, depression, health impairments, and emotional challenges to those who have experienced significant loss. This is particularly true when the survivor felt protective of the deceased. For example, parents whose children die are at significant risk for survivor guilt, believing that they should have died rather than their child. Parents defer to the "natural order of things" with words like, "I should have gone first." This is partly a statement of the pain of grief, and largely a statement of self-blame for not having been able to protect the child. Children who lose a sibling frequently experience survivor's guilt, believing that somehow the parents' grief would be less if they had been the one to die instead of the sibling. These children may also experience relief that they did not die, adding to the survivor guilt experience.

Part of the pathology of guilt in survival is a skewing of the ability to relate to others about the survival event. The survivor may hold their guilt inside like a terrible secret. Their assumption seems to be that no one else will understand it, so the survivor needs to hold onto it so that the memory

will not be destroyed by others. For these survivors, the guilt becomes a shield to both protect them from other feelings and hold others away from the internalized pain about the survival event. Survivors frequently report subsequent difficulties in relationships with trust and expressing needs. There is a sense that others cannot meet one's needs, and that entering relationships out of need makes one vulnerable again to loss. Often, the survivor works hard in business relationships, but does not enjoy the work or its product because of ongoing feelings of unworthiness and impending doom. Guilt becomes a response to inhibit impulses and avoid fully engaging life. This attempt to control relationships and vulnerability is a normal defense mechanism for bereaved survivors.

Primary Identification

The term *survivor guilt* has been primarily identified with Holocaust survivors. Authors such as Aaron Hass and Elie Wiesel have written about the experience of guilt in the face of the death of friends and family members at the hands of the Nazis. Survivors, as well as their families, wonder why they lived while others died. Even more devastating, they wonder if their own drive to live contributed to the death of others. When resources like food and water are too scarce, securing them for oneself means denying them to someone else, and survival begins to be viewed as intentional harm to others. This example of "content survival guilt" reflects a belief, in fact an acknowledgment, that their survival came at the cost of lives.

Holocaust survivors have dealt with survivor's guilt in a number of ways. One of their prevailing feelings is a sense of helplessness. Survivors commonly try to deal with these feelings by attempting to control the future. They justify their survival to be witnesses to the atrocities, to make sure that their loved ones are not forgotten, to make sure it never happens again, and to create new families to continue the family line. These coping mechanisms help survivors find meaning in their own survival and existence. Viktor Frankl suggests that there should be no such thing as survivor guilt, only survivor responsibility, by which he means that survivors address the guilt and use it as witness to the atrocity in order to ensure that it can never happen again. Survivor responsibility answers the question, "Why did I survive?" with the determination to tell the story and to preserve the family and race. This attempt to find meaning is evident both in survivors of the Holocaust and in their children. This phenomenon is shared by others who experience survivor's guilt and subsequently engage in busyness designed to justify their survival.

Psychological Phenomenon

Issues of helplessness, control, and meaninglessness are also experienced by survivors of tragedies and losses other than the Holocaust. Many survivors experience guilt that manifests itself as the need to inhibit impulses and control responses to others. It is not unusual for survivor's guilt to manifest itself through depression or anxiety. Survivors who feel that their survival came at the expense of others may often withdraw from social relationships, experience physical complaints, disturbed sleep, mood changes, or all of the these conditions. In some cases, the depression is anger turned inward to avoid the personally unacceptable sense of rage at the cause of the tragedy. Anxiety is frequently accompanied by depression in survivor guilt.

An associated risk factor in survivor's guilt is that of suicide. Survivors who struggle with believing they have a right to be alive are at risk of suicide when depression and hopelessness prevail. There can be a sense that the only answer to the internal pain is personal death, a resolution to the issue of having survived the original event.

Therapeutic Responses

In the aptly named movie *Ordinary People* from 1980, young Conrad is depressed and suicidal after the drowning of his brother and the emotional withdrawal of his mother. When Conrad tells his therapist that he is being punished for doing "one wrong thing," the therapist asks what it was. Conrad replies that his sin was to hold on when his brother let go. The therapist's response to such a situation should help reframe the painful event to help the individual see the potential to share the story of the event. There is opportunity to make meaning out of their survival in a way that says, "I can live with that."

Survivor's guilt is often underreported because it is ignored or missed. Ideally, therapeutic

responses should begin immediately after a tragedy in which survivors are identified. These include providing the opportunity for the survivor to tell their story in a safe environment with unconditional acceptance and lack of judgmental response. Friends, family members, and first responders can all be listening ears to hear the stories of survivors. It is also essential to restore safety as soon as possible and to approach safety as an inherent right for all people. Reestablishing routines is also therapeutic for survivors. One effective method for meaning making and re-engaging decision making is the use of ritual. Examples include memorial services, dedications of hallowed ground, and ceremonies of commitment. Surrounded by family and friends, encouraging the survivor to tell the story as a part of the ritual can help the survivor to begin to tell the story and gain the confidence of sharing the event and pointing to the meaning in the story.

For those survivors whose survival guilt manifests as anxiety and depression, it is important to assess the scope of the feelings and refer to a mental health professional when the anxiety or depression prevents them from functioning normally. It is essential to assess for suicidal thoughts and plans as well. Some individuals experiencing survivor's guilt may require medical treatment with antidepressants, particularly during times of elevated risk of suicide.

The resilience necessary for survival is the key ingredient for dealing with survivor's guilt. Normalizing the response, treating any accompanying depression and anxiety, and validating the meaning of the survivor's life are essential. Helping survivors recognize that their survival means there has been both misfortune and fortune for them helps them acknowledge their right as well as their responsibility to continue.

Conclusion

Hope for the person with survivor guilt starts by talking about the event in an environment with supportive friends and family. The process of telling the story will help identify the meaning in the event, thus reframing the event from a source of guilt to having greater meaning and hope.

Helen Harris and James W. Ellor

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Symbolic Immortality

The concept *symbolic immortality* was developed in the research conducted on survivors of the atomic bombing of Hiroshima, Japan. Robert J. Lifton theorized that humans have a basic and compelling need for mortality transcendence, and that the quest for a sense of continuity that extends farther than one's natural life is a universal phenomenon made possible by self-knowledge of the inescapability of death. The need for, and the quest to achieve, a sense of connection and continuity was what became known as "symbolic immortality." This concept is one of the most widely used and influential thanatological theories, and it has important implications for a wide range of social scientific approaches to the study of dying, death, and the human response.

The work to achieve a sense of symbolic immortality plays an important role beyond that of providing a sense of continuity in the face of death; it is also an essential requisite of psychological well-being. Achieving a sense of symbolic immortality is one possible way of assuaging the certainty—and oftentimes fear—of death by transcending the most potent conception of what death signifies, namely the severed connection to the present and future and to the world of the living. To attain a sense of symbolic immortality is to become less susceptible to the crippling fears of dying and death; it is to be less threatened by the certainty of one's anticipated demise, and ultimately, to

approach death as a natural part of the cycle of life. The quest to achieve a sense of symbolic immortality is something all healthy individuals do, and in its absence, individuals risk developing psychic numbing or desensitization to life's experiences coupled with a loss of meaning. Studies of the survivors of Hiroshima's atomic bombing found that psychic numbing was pervasive, and that it led to a host of psychological problems in many who endured the experience. Achieving a sense of symbolic immortality helps not only to manage the terror and fear of dying, it also brings a sense of ontological order to the challenges and uncertainties of life.

It is theorized that people attempt to achieve a sense of symbolic immortality through fives modes of transcendence: the biological, creative, religious, natural, and experiential transcendent. Individuals can use one or multiple modes of transcending death, but what is crucial is that individuals attain a sense of continuity.

The Pathways to Symbolic Immortality

Biologic Symbolic Immortality

The most accessible means to achieving a sense of symbolic immortality is through the biological mode, most specifically through familial progeny, whether blood or adopted descendants. Having children provides parents with a bond to future generations in that decedents "exist" in the blood ties that bind their generation to the future. This pathway also offers individuals the chance to continue "living" in the memories of children, family members, and close friends and associates.

The biologic mode includes the sense of symbolic immortality derived from the transmission of cultural patterns from one generation to the next. When parents transmit cultural norms, religious or ethical doctrines, and worldviews that are specific to their ethnic, racial, or national identity, these social facts become an unbroken chain of shared ethos between the past and the future.

Creative Symbolic Immortality

The second pathway to achieving a sense of symbolic immortality involves artistic endeavors and/or creative acts, things that will outlive the decedent and have an influence over future generations. Robert J. Lifton envisioned the creative mode as one where personal accomplishments would be a lasting inspiration for other individuals long after one's death. Creative activities, such as works of literature, scientific endeavors, artwork, music, and/or any creative artifact that individuals might leave for others, are means to achieving a sense of symbolic immortality. Picasso, Van Gogh, Cezanne, Warhol, and Pollock are examples of individuals who have achieved an apagogic level of creative symbolic immortality in their *objet d'art,* as every successive generation rediscovers their work, engages their paintings by ascribing novel interpretations to them, and uses their techniques as inspiration for their own artistic creations.

A common method of achieving creative symbolic immortality is through one's work or career. The example of teaching as a vocation is one that provides a straightforward route to the sense of symbolic immortality. When teachers educate their pupils, they are simultaneously forming close relationships, albeit for the purpose of knowledge transfer, and this information transaction enables teachers to continue their existence in the minds of future generations. The same is true about the close relationship between the physician and patient, counselor and counselee, and the mentor and apprentice. These nonfamilial bonds can lead to a sense of symbolic immortality: creative symbolic immortality is an expression of the bonds of social influence.

Religious Symbolic Immortality

The third method of achieving a sense of symbolic immortality is through religious or theological beliefs and practices. To transcend death through religious means is to accept that one's mortal demise is not the end, and that there is continuity on a spiritual realm, whether that is the hereafter (heaven or hell) or some other manifestation of immortal existence. All major worldly religions have attempted to confront the existential problem death imposes on the human psyche through theological accounts of what happens after death. Many religions have an eschatological narrative and belief in a heavenly kingdom or realm of consciousness that adherents will experience after dying. Most religions provide adherents a security that death is a passage from this life to a much

more elevated and sacred existence. By accepting the spiritual transcendence of death, people can face their mortality without anxiety or terror. In essence, achieving a sense of religious or theological symbolic immortality serves as a mechanism of terror management given the continuity provided. Most Christian denominations propagate a theology of the eternal soul, believing that a decedent will continue to exist on a higher plane and in a superior form. In addition, the cycle of reincarnation and variations on the eternal soul characteristic of many Eastern religions play a similar role in responding to issues relating to human suffering.

Natural Symbolic Immortality

The fourth pathway is through the connection an individual might experience with nature, other living organisms, and the material world. This mode reflects a sense of deep connection between self and the natural environment because humans, as living organisms, are also part of a larger bionetwork.

Experiential Symbolic Immortality

The last type of symbolic immortality is experiential transcendence and is believed to be the most important expression of this phenomenon. Experiential transcendence relates to powerful and engrossing experiences where individuals are immersed to the point of losing themselves psychically, if only temporarily, by the sheer exuberance of the encounter. What is truly unique about this form of symbolic immortality is that it can manifest itself in each of the other types. For instance, the experience of childbirth could be a transcendent one for the parent(s) involved; likewise, the experience of a religious conversion, such as being "born again" in the Christian sense, or in Eastern religions, the experience of nirvana or enlightenment is an experiential transcendent one. This encounter can also occur in the creative realm, such as through one's music, artwork, or that of a charismatic performer. The act of sex, the moment of orgasm, and the intensity of intimate encounters also represent experiential transcendent moments. Finally, the use of psychotropic substances can also be a type of experiential transcendent phenomenon. These transcendent experiences are times when an individual might feel especially alive and spirited, and one where the individual is temporally absorbed in the present moment—not thinking about the past or the future.

Empirical Studies on Symbolic Immortality

Over the past 25 years, there has been extensive empirical research based on Robert J. Lifton's theory of symbolic immortality. The majority of these research findings suggest that humans desire a sense of symbolic immortality, including the quest to achieve this status, play influential roles in people's lives, not the least in assisting their management of the terror and fear of death, the most obvious implication of achieving a sense of symbolic immortality.

A 1998 survey of 420 Jewish Israelis, employing the Symbolic Immortality and Fear of Personal Death scales, demonstrated that those subjects who had a well-developed sense of symbolic immortality also had a protective shield against the terror and anxiety of death. These individuals were more likely to report low levels of fear about personal death.

Earlier research in the 1990s by Jean-Louis Drolet has revealed that the fear of death is lessened when individuals have achieved a sense of symbolic immortality. Finally, in the 1970s, Robert Kastenbaum found evidence that seemed to support the role of the biologic mode of achieving a sense of symbolic immortality. In a survey of 532 individuals, Kastenbaum reported that 90% of the sample agreed that people who have descendants, namely their own biologic progeny, have much less difficulty facing death than those who remain childless.

Threats to Achieving a Sense of Symbolic Immortality

The theory of symbolic immortality arose out of studies of survivors of the atomic bombing of Hiroshima. One of these findings was that many survivors existed in a state of "mimetic death," where they became psychically numb to life's experiences as a survival and coping strategy after witnessing the horrors of atomic annihilation. The atomic experience threatened their sense of symbolic immortality through the natural and biological modes because of the destructive power of the bomb, and the tens of thousands of immediate

deaths it caused. Consequently, the theory posits conditions where the quest to achieve a sense of symbolic immortality might be threatened or hampered because of extreme phenomena. For instance, massive environmental degradation caused by global warming, industrial pollution, and suburban creep could, in fact, affect attempts to achieve a sense of symbolic immortality through our connection to the natural world. A threat to achieving a sense of biologic immortality is the risk of nuclear war and the worldwide deaths that would likely result. Likewise, a threat to the religious mode of symbolic immortality might be increasing secularization and the rise of scientific rationality over the last century. Of course, the possibility of achieving a sense of symbolic immortality in other routes remains because of the multiple pathways to this end.

Lee Garth Vigilant

See also Death Anxiety; Immortality; Life Review; Postself; Terror Management Theory

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Symbols of Death and *Memento Mori*

Images or symbols that represent death have been incorporated into visual and literary culture since classical antiquity. They range from more overt personifications of death, such as a skull or the familiar black-hooded figure carrying a scythe popular at Halloween, to more abstract and subtle depictions, such as an hourglass or broken-stemmed rose. The term *memento mori* is a Latin phrase that may be loosely translated to "remember you must die," and the term is applied to visual or textual references to death, overt or symbolic, that are intended to remind the viewer of his or her own mortality.

Classical Antiquity

While *memento mori* may be Latin, the term was rarely used by the Romans, as they preferred the well-known *carpe diem*—seize the day. The intent was the same, however. The viewer was reminded to live life to the fullest, as death could strike at any moment. In Petronius's *Satyricon,* chapter 5, at a banquet hosted by Trimalchio, a slave brings in a silver skeleton with moveable joints. After the skeleton is tossed so that its limbs assume a variety of positions, Trimalchio ponders the brevity of life and exhorts his guests to enjoy life while they can, as they are all destined to one day look like the skeleton. The Romans also incorporated imagery that referenced the carpe diem theme into everyday objects. A 1st-century table top mosaic at Pompeii depicts a skull hanging from a carpenter's level. Its bony chin sits atop a butterfly that rests on a wheel of fortune. From the balance hang the garments of the wealthy on the left and a beggar on the right, indicating that death does not discriminate to class or occupation.

Medieval and Renaissance

While the Romans wanted to remind the viewer of his mortality so that he could live a full life, it was Christianity that incorporated a more cautionary note into the concept of memento mori. This more serious tone is linked to the medieval concepts of the "good" and "bad" death. If one found

himself unexpectedly on his deathbed, having lived a good and pious life would make the moment of death less frightening, as certainly an exemplary life would ease the passage to salvation. Those whose lives had been less than exemplary might not have time to repent their sins before they died, and thus their salvation would not be assured. Because, as in Roman times, death could strike without warning, the church encouraged the faithful to contemplate their mortality daily so that they would be ready to face death when it came. Representations of rotting and decaying corpses were especially popular, as they were a clear reminder of the fragility of one's corporeal self. Images such as *The Three Living and the Three Dead,* from the de Lisle Psalter (ca. 1300–1310, British Library), were especially graphic reminders of bodily decay, as the Psalter contrasts the images of three living men with those of three rotting corpses, complete with worms and ragged shrouds. Skeletons and decomposing corpses were also depicted on "cadaver tombs" especially popular in the 14th to 16th centuries. The tomb of Sir Roger Rockley (d. 1534) in Worsborough, England, and the tomb of Jean de LaGrange (1402) in Avignon are typical examples. As in the Psalter, the tombs contrast a representation of the whole body of the individual with that of the decaying corpse.

Personifications of death itself joined these other reminders of mortality in the 15th and 16th centuries. Hieronymus Bosch depicts death in one of his most well-known incarnations as a skeleton carrying an arrow in *Death and the Miser* (ca. 1490, National Gallery of Art, Washington, D.C.). Here, death attempts to squeeze through the bedroom door of an elderly miser who is trying to decide if he will accept the salvation offered by the angel at his right or be tempted by the demons lurking under the bed. Death depicted as a skeleton also appears in other didactic texts, such as *La Danse Macabre* (The Dance of Death), versions of which may be found well into the early 19th century. In this text, death is usually depicted interrupting the living at their work or leisure and attempting to lead them away from their earthly lives. The living are often surprised and reluctant to heed death's summons. The texts generally emphasize death's indiscriminate nature both as to time and rank. Death may just as easily come for an elderly monarch as for a young beggar child or middle-class merchant. Thomas Rowlandson's version injects some humor into these scenes. In *The Last Chase* (ca. 1816), death grasps an arrow as he sits astride his equally skeletal horse and grins merrily as he leads a group of men in the midst of a foxhunt off the edge of a cliff.

Less overt references to death and mortal decay were also popular in Dutch genre paintings of the 17th century. Although the predominately Calvinist Dutch did not favor overtly religious artwork as did their Catholic neighbors, they, nonetheless, believed that even the simplest genre scene or still life should have some type of didactic message. To that end, painters often employed *vanitas* symbols into their compositions, particularly still lifes to remind the viewer of the transience of life. These reminders of earthly vanity could draw on traditional memento mori imagery, such as the watch and skull included next to the violin, book, and other objects in Pieter Claesz's *Vanitas Still Life* (ca. 1630, Mauritshuis, The Hague). However, vanitas imagery could also employ even more subtle symbols, such as the peeled lemon or broken glass in Wilhelm Claesz Heda's *Still Life With Oyster, a Silver Tazza and Glassware* (1635, Metropolitan Museum of Art). Like the more well-known symbols, the lemon and glass nestled among the other luxury objects spoke of material wealth and prosperity. They would have been familiar to the prosperous Dutch merchant class and would have reminded them that despite the beauty of these objects, they, like the entire corporeal world, were transient and would decay.

In addition to these more public references to death found on tombs, in didactic texts, and in paintings, memento mori imagery could also be found on more personal objects used within the home or worn on the body. From at least the 14th century until the early 20th century, a variety of objects were produced with familiar symbols of death that at once reminded the viewer of their own mortality but also functioned to remind one of his or her duty as a mourner. These objects ranged from fans, gloves, and silver spoons with a small skull on the handle to snuff boxes shaped like a coffin with an inscribed hourglass on the lid. Mourning rings, pins, fans, and other commemorative objects were especially popular for both sexes in the 18th and 19th centuries and employed a variety of

familiar symbols: skulls, urns, hourglasses, weeping willows, and phrases: "behold death," "live to die," and, of course, "memento mori." Lockets, pins, and rings could be inscribed with the deceased's initials and have a compartment in which to display a lock of the deceased's hair.

The Modern Era

Although the skull and skeleton would long remain symbolic standards, a significant shift occurred during the 18th century in the types of symbols that were used to represent death. Enlightenment ideals that sought to replace ignorance and superstition with knowledge and the scientific method also influenced Christianity and the conceptualizations of death and dying. As medical science gained more control over the pain of death through medications, the terrors of the deathbed and the fears of damnation were de-emphasized in favor of a more peaceful end. This shift can be illustrated through Puritan gravestones found in the northeastern United States. Gravestones from late 17th and early 18th centuries often depict the familiar skull: an inverted pear-shaped head with wide holes for eye sockets and septum and a row of square teeth below. Throughout the century, however, the more terrifying skull transforms into the head of an angel: the skull becomes fuller and rounder, wings spring from the sides, the eye sockets are no longer empty and the rows of teeth become lips that curve into a gentle smile. The viewer is now reminded of death, not through a representation of the corruption of the body, but by a representation of a heavenly messenger.

In the 19th century, although death continued to be imaged as a skeleton dressed in a cloak and carrying a scythe, especially in popular culture, representations of death and mortality on the whole were more abstract and less frightening than depictions from earlier centuries. Many of these symbols borrowed from the more restrained neoclassical tradition; broken columns, down-turned torches, cloth-covered urns, and women dressed in classical garb standing mournfully at the graveside were popular motifs on tombs and gravestones, as well as on the numerous objects associated with mourning that were previously discussed. Romanticism, which in part emphasized the expression of emotions and the primacy of the imagination over reason, too, had its influence. The deathbed was often characterized as a blessed event where the dying would be released from the woes of the earthly realm. Death was discussed using metaphors of sleep and rest or traveling to a new realm. Sculptures of grieving angels now stood at the graveside, along with carvings of weeping willows, roses, or the popular disembodied hand that pointed heavenward.

Contemporary Symbols

As the 20th century progressed and the experience of death and dying was slowly removed from the domestic environment and from within close proximity of the living, these less-overt symbols also began to disappear. Modern graves generally do not incorporate memento mori imagery. Symbols of death did not disappear altogether, however. The November celebration of the *Dia de los Muertos* (Day of the Dead) in Mexico keeps alive many of the traditional references to mortality. The yearly festival, which honors deceased friends and relatives, incorporates the familiar motifs in a variety of ways. Small shrines are set up in the home with images of the deceased and candles and offerings of food and drink. Special toys, baked goods, and chocolate candies are fashioned into skeletons, skulls, or coffins, and these too are left in honor of the dead. Although the often whimsical or comical treatment of these objects belays the terror of depictions from earlier centuries, they, nevertheless, function in the same way: the living are reminded of their own mortality.

Contemporary artist Damien Hirst provides a final example of the tradition of memento mori imagery but with an intriguing twist. His *For the Love of God* (2007) is a human skull encrusted with over $1 million worth of diamonds. The traditional symbol of mortality and bodily decay has been transformed into an object of glamour and wealth. Perhaps like the Dutch Calvinists from the 17th century, Hirst intends to remind the viewer of both the luxury of this world, and the inevitability of leaving it all behind.

Terri Sabatos

See also Dance of Death (*Danse Macabre*); Day of the Dead; Halloween; Popular Culture and Images of Death

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Taoist Beliefs and Traditions

See Daoist Beliefs and Traditions

Taxidermy

Taxidermy is the art of preparing and preserving the skins or parts of the bodies of animals, birds, reptiles, fish, or other creatures, and then mounting them in such a fashion so as to appear in a lifelike state. The craft of stuffing animals is centuries old, but the process was accomplished in a crude fashion until the late 18th century, when somewhat more sophisticated procedures were employed. By the early 20th century, modern taxidermy had evolved and was capable of producing extraordinarily lifelike specimens. Taxidermy has long been popular in the United States because Americans perceive a certain organic beauty in animals and birds, even if dead. Taxidermy converts the corpses of deceased creatures into seemingly live statuary, but frozen in time and place. Taxidermy products are quite diverse and can be categorically divided into eight different varieties.

Taxidermy is both a zoological art form and a thanatological art form. It is a zoological art form in that it produces mounted specimens of animals, birds, and fish in their natural state for the edification and pleasure of those who view them. The mounted creatures may serve a number of manifest functions, including education, enlightenment, entertainment, amusement, utility, attracting interest, and impression, mood, atmosphere, and emotion management. From the thanatological perspective, the practice of taxidermy has latent functions that seek the refutation of death. One latent function of taxidermy is that it serves to acquaint the viewer with the reality of death. Even though the animal is dead, the skilled taxidermist can restore symbolic life to the creature by giving it the impression of both viability and reanimation. Taxidermy can be seen as transcending death by projecting the image of life.

In the past, taxidermy was categorized as a socially marginal art, but today there is a strong emphasis on aesthetics in mounting animals. Taxidermy involves a number of technical protocols, such as tanning the skin, inserting and properly positioning glass eyes into the eye sockets of the form, fitting the hide to the form, and sewing the skin to tighten the hides on the form. Taxidermy is a unique enterprise in that it seeks to create nature in the form of dead animals, imitate art in the shape of organic statuary, rather than art imitating nature.

Taxidermy in American Life

Taxidermy has a strong and visible presence in American culture, as it appears in television, movies, commercial establishments, household items, clothing, and even in humor. Taxidermy has been institutionalized as an American folk craft. At one time, taxidermy skills were so desirable that the Boy Scouts of America awarded a merit badge to scouts who mastered these skills.

Taxidermy can be an avocation, occupation, or both. Many individuals originally take it up as a hobby, but often after acquiring and perfecting their skills and developing a sense of aesthetics and artistic creativity, they pursue the skill commercially. The most remarkable aspect of taxidermy is the fact that the great majority of taxidermists acquire their expertise via mail order correspondence courses.

Taxidermy and Cultural Utility

Taxidermy specimens are employed in various configurations for different social purposes and serve several functions in American culture. An examination of the various categories of taxidermy demonstrates the diversity of forms and functions that taxidermy manifests. Taxidermy can be divided into two distinctive levels of cultural goals:

1. *Specific*. The specific goal is to seemingly restore life to dead creatures so that they can be viewed, scrutinized, and admired in their natural appearance at close hand. The mounted specimens provide that opportunity.
2. *Diffuse*. The goal is to achieve a more subjective result. The intent is to alter the cognitive attention or emotional state or mood of the viewer upon viewing the specimen.

Patterns of Social Purpose

Both of the previously mentioned goals can be further divided into four patterns of social purpose, namely (1) interest/attention management, (2) impression/image (persona) management, (3) impression/atmosphere (ambience) management, and (4) emotional/mood management. Each of these patterns involves the management of variant types of perception. The resulting typology consists of eight subvarieties of taxiderminological enterprise with widely varying motivations and products. These include:

1. Scientific or display taxidermy
2. Trophy taxidermy
3. Craft (utility) taxidermy
4. Novelty taxidermy
5. Advertising taxidermy
6. Fashion taxidermy
7. Decor or decorating taxidermy
8. Nostalgia taxidermy

Instrumental Cultural Goals

Instrumental taxidermy involves mounting dead creatures for four special purposes, namely to inform, to impress, to perform tasks, or to amuse. To achieve these goals, the creatures must be preserved in a naturalistic and lifelike fashion to accomplish the first two purposes, but in a convoluted or bizarre fashion to accomplish the last two.

Scientific or Display Taxidermy

Scientific or display taxidermy could be called museum taxidermy. From this perspective, taxidermy is a scientific or naturalist craft and art. The mounted specimens are interesting, enlightening, and educational. This type of taxidermy is used to create, manage, or manipulate interest in zoological topics. It was through such educational interest that taxidermy first entered the American home. A recent variation of the traditional wildlife museum is having mounted animals placed where blind persons, especially blind children, can feel them. Visitation that involves feeling the animals is called sensory safaris.

Trophy Taxidermy

One of the more commonly encountered forms of taxidermy in the United States is that of trophy taxidermy. In some parts of the United States, such as in the South or the West, a great many homes, especially in rural areas and small towns, will have a mounted deer head or a large mounted fish on the wall. These mounted trophies offer tangible, visible evidence of the individual's hunting or fishing success. Such trophies may also be found in restaurants or other places of business. Mounted exotic animals from Africa or Asia may be displayed as status symbols of affluence, foreign travel, adventure, or danger.

Craft or Utility Taxidermy

Early in the evolution of taxidermy, practitioners perceived that there was a utilitarian dimension to the art, and they designed and produced a wide array of useful articles using the remains of dead beasts to shape and form a variety of items for household purposes.

Utility taxidermy might include such useful artifacts as elephant feet waste baskets, lamp bases made of bird and animal parts, or knife handles made of deer feet. The American national character has a penchant for the unusual, such as dead animals being converted into artifacts.

Novelty Taxidermy

Just as some paintings and sculpture may be compelling as an object of attention, taxidermists are capable of producing artistic creations with similar characteristics—novelty taxidermy. By reassembling mismatched portions of dead animals, new and bizarre species are created that have no real live counterparts. Such taxidermy specimens may assume various modal configurations. The production of such chimeras is sometimes referred to as rogue taxidermy.

Another form of novelty taxidermy is *tableaux-morts* or anthropomorphic taxidermy. In this mode, a group of small common animals, often kittens, puppies, or rabbits, are mounted in human group situations depicting events such as weddings, poker games, or a uniformed band marching down the street with tiny musical instruments.

Diffused Cultural Goals

Taxidermy is used to achieve generalized goals, such as creating a mood or state of mind, or to influence the perception and judgment of the observer. The intent is to enrich the visual inventory of an image and thus influence the viewer's interpretation.

Advertising Taxidermy

Mounted animals, birds, fish, and especially exotic creatures, are eye catching. Accordingly, they are often used as displays and for advertising purposes to attract the attention of prospective customers. Many popular magazines feature ads for products in which animals are included. These are frequently lifelike mounted animals, which are sometimes trademarks.

Fashion Taxidermy

The use of animal parts can also be used in costume, and the animals preserved by taxidermy may significantly add to the construction. Clothing is a costume, and costumes augmented by taxidermy produce a special kind of costume. By wearing a particular costume, the individual can create and project a desired persona. Accordingly, Americans and members of many other societies like to wear costumes that utilize various zoological elements, such as fur, feathers, hides, or even portions of the creature itself. Animal, bird, reptile, or fish skins and parts have always been used as status symbols to create a persona or convey a social message.

Décor Taxidermy

In the early development of taxidermy, mounted specimens of animals, birds, fish, or reptiles appeared in museums and business establishments. They quickly moved to the home, the presence of which was initially rationalized as educational and scientific. Hunting trophies in the form of animal skins, hides, and horns followed. Whether it is in home or commercial establishments, taxidermy products aid in creating an ambience and, thus, a way of managing the impression of others.

Nostalgia Taxidermy

The death of a pet can be emotionally traumatic for many individuals. For such individuals it is difficult to let go, and they seek to retain something of their beloved companion, if even nothing more than a dead body. Nostalgia taxidermy is a way of managing grief and dealing with the emotional loss of the pet. The dead dog, cat, or horse can be mounted and retained. The bonds will not be totally broken as long as the taxidermy effigy of the animal can be seen, touched, and stroked. In recent years, some taxidermists have offered the

service of freeze-drying dead pets. By preserving the pet, memories of the past are preserved.

Clifton D. Bryant and Donald J. Shoemaker

This entry is an abridged and revised version of an article authored by Clifton D. Bryant and Donald J. Shoemaker that originally appeared in *Free Inquiry in Creative Sociology*, *16*(2), 195–201, November 1988. Adapted with permission.

See also Depictions of Death in Art Form; Depictions of Death in Sculpture and Architecture; Popular Culture and Images of Death

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Terminal Care

Terminal care is health care given to people at the end of life when curative measures have been exhausted and supportive palliative care is more appropriate. Terminal care focuses on maintaining good quality of life, relief of suffering, and physical, psychosocial, and spiritual support during the last days and weeks of living.

Recipients of Care

The terminally ill person and family or significant others are the focus for terminal care. Professional caregivers provide the physical care for the patient, or assist the family in giving care, but the psychosocial and spiritual care is appropriate for all. The patient may be in a hospital, a nursing home, an inpatient hospice, or at home. A criterion for hospice care is a life expectancy of six months or less as determined by two physicians. Though hospice personnel are well known for excellent end-of-life support, well-trained professionals can provide appropriate terminal care to patients in all the previously mentioned settings.

Providers of Terminal Care

The providers collaborate with the patient and family to give comprehensive, holistic, compassionate care. The head of the health care team is the physician who determines that curative care is no longer indicated and that the patient is terminally ill. The physician, in consultation with the patient, family, and other caregivers, orders medications and other therapies for symptom relief. In home care, a family member is usually the primary caregiver, with assistance from other relatives and friends or professionals. In the inpatient setting, nurses are the primary caregivers, but family members are often involved there as well. A social worker assists with financial concerns, evaluates the home for adequate facilities for home care, and may serve as a counselor. The pharmacist is available for consultation regarding medications and dosages, particularly for pain management. The chaplain provides spiritual support. A physical therapist may assist the patient to retain strength and flexibility to increase comfort. Professionals from other specialties may also be called in to offer nonpharmaceutical alternative approaches for relaxation, pain management, and psychological support. These may include a music therapist, an acupuncturist, and/or a specialist in healing touch, massage therapy, and/or guided imagery.

The majority of patients in hospice care have a diagnosis of cancer. Other diagnoses include chronic respiratory disease, congestive heart failure, stroke, Parkinson's disease, amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), and congenital syndromes that shorten life. The terminally ill patient may also be the victim of trauma

or another sudden event for whom curative care is no longer effective or appropriate.

Aspects of Terminal Care

The focus of terminal care is comfort. The interventions are directed toward that goal. Some have described terminal care as necessary when "nothing else can be done." It is helpful for the family and caregivers to recognize that terminal care involves "doing" many things to bring good quality to the patient's last days.

The initial assessment of the terminally ill person includes a determination of distressing physical symptoms: emotional, social, and financial concerns; worries about "unfinished business"; anxiety about symptoms and approaching death; and spiritual concerns. In the ideal situation, every effort is made to relieve both physical and emotional suffering.

Physical Symptoms

Physical symptoms must be addressed first. If the physical symptoms are controlled, the patient is better able to be involved in the psychosocial, emotional, and spiritual tasks that are of concern.

In terminal illness, several body systems may begin to fail and create problematic symptoms. Pain is usually the most important symptom that concerns the patient and the family. Some sources of pain are the primary disease, metastases, immobility, respiratory distress, or infection. Some other symptoms are as follows:

Nausea, vomiting, and loss of appetite

Dehydration

Urinary and bowel incontinence

Constipation

Reductions in ability to walk, talk, or hear

Skin breakdown

Mental confusion

The professionals who care for the terminally ill sensitively and thoughtfully evaluate the symptoms that are bothersome and, in concert with the patient and the family, determine the most helpful interventions. Because pain is the overriding concern, the appropriate medications and dosages are crucial to management. The terminally ill patient may need high dosages of narcotics to get relief, but he or she usually wants to remain alert as well. It is a balancing act to assure both. Worries about addiction are not appropriate in a terminal care situation.

Terminal care is not curative, but curative interventions may be used as palliative interventions. For instance, if a tumor is large and causing pain or other symptoms, radiation or chemotherapy may be used to reduce the size of the tumor. There is no expectation of cure with these interventions. Similarly in terminal care, intravenous fluids are not used routinely. At times, however, dehydration may become problematic and specifically cause mental confusion. Intravenous fluids may be indicated to relieve this troublesome symptom.

Emotional Concerns

Emotional care of the terminally ill and their family members is of primary importance. Emotional distress reduces quality of life significantly. Everyone involved in terminal care has the potential to identify emotional concerns and provide kind and compassionate listening, support, and encouragement.

The following are some of the emotional concerns that may be expressed by someone who is terminally ill:

Anxiety and fear of approaching death

Worries about the financial and emotional well-being of loved ones

Regrets, "unfinished business"

Anger at God, self, and others

Denial of the prognosis

Inability to communicate fears and worries

Depression

Some of the emotional distress may be relieved with medication for depression and if pain and uncomfortable symptoms are relieved. Though

patients may not be able to talk openly with family members because of concerns about making them sad or uncomfortable, they may talk with outside caregivers or friends. One may earn the privilege of sharing this important communication by establishing a warm, trusting, and nonjudgmental relationship in all patient interactions.

Family members also need a great deal of emotional support as they anticipate the approaching death. They need a listening ear, a shoulder to cry on, and a break from the constant stress of giving care and facing the suffering of their loved ones. Professional caregivers and friends help provide emotional and physical respite to them.

Interpersonal Relationships

In the last days of a terminal illness, the patient usually has decreased energy and may not be able to interact well with others. Participating in previously enjoyed activities is impossible. At times the patient will withdraw and gradually reduce outside contact to just a few immediate family members and caregivers. The caregivers support this need by allowing time for the family and patient to be together and protecting them from outside visitors who may not be needed at that time. Well-meaning friends can be encouraged to send cards, bring food, or spend time with the family members who need support and conversation. Wise caregivers can gently affirm to the visitors that they are serving the patient by their support of the family.

Conversely, some friends and distant family may avoid visiting the patient because of discomfort being around the terminally ill and uncertainty about what to do or say to the patient or family. Caregivers may have the opportunity to intervene by speaking with friends and family whom the patient would like to see and assuring them that "just being there" is all they need to do.

Spiritual Care

Some people are religious and find great comfort in their religious beliefs as the end of life draws near. Family members also find comfort and hope in their faith that they will be reunited after death with their loved one. Support from their minister or the agency chaplain is important to them and necessary for making their last days rich and meaningful.

The patient may be at the other end of the spectrum and be angry with God and frustrated with the platitudes of religious groups. An effective spiritual advisor allows for the expression of emotion and finds ways to encourage and move the person toward some satisfying resolution of conflicts if at all possible in order to make the last days as peaceful as possible.

Some do not have a formal religion but will find spiritual encouragement from reflecting on their lives and the contributions they may have made to others and to the community. They may be comforted by meditation, music, beautiful art and writing, or a number of other things that give meaning to life. The caregiver facilitates and obtains what the patient needs for spiritual support.

Ethical and Legal Issues in Terminal Care

Terminal care implies that all concerned are aware that the ill person has a short time to live. Resolution of certain legal and ethical issues will enhance this period for both the patient and the family.

In many situations of terminal illness, the patient has a living will and durable power of attorney for health care document, especially if the care is being delivered in a nursing home or hospice. This written, notarized declaration guides the family and the health care providers to the patient's preferences regarding care. In terminal care, the patient and the spokesperson for the patient have usually determined that no further extraordinary measures will be undertaken. This opens the door for the philosophy of comfort and relief of suffering to be the overriding goal of all decisions in care, including artificial nutrition, resuscitation, and artificial respiratory support by ventilator. It is important to note that the patient and the spokesperson may change their minds about their decisions at any time. Open communication among the patient, family members, and the physician will allow for discussion about the futility of extraordinary care and will assist in bringing all to a consensus about comfort care.

In hospice or comfort care, if the patient is unable to eat and drink, there is no additional effort to force nutrition. Research in hospice care has shown that as the body begins to "shut down" there is no need to force nutrition and fluids. Patients do not show signs of discomfort other

than dry mouth and lips. The caregiver helps relieve these symptoms by offering ice chips, gently swabbing the mouth with a moist sponge, and lubricating the lips frequently. As death approaches, many patients seem to breathe more easily and have less respiratory discomfort when their lungs do not contain excess fluid. In other words, "letting nature take its course" provides the patient with a seemingly more comfortable dying process than using artificial support.

One dilemma for the patient and the family may be the fear of stopping treatment too soon. The health care providers can reassure them that the disease process has overcome all the treatments currently available, and that they have done all that is possible to give the patient a chance to live longer. When the family members and the patient consider the choice between extending suffering versus providing a comfortable quality of life, most are satisfied with the choice of no more attempts at curative measures.

Indicators of Approaching Death

Communication is extremely important between caregivers and the family in the care of the terminally ill, and no more so than when death approaches. The family will often begin to ask about the signs that the end of life is near. Some of the possible changes are as follows:

Confusion and agitation

Unresponsiveness

Cool and bluish extremities

Purplish coloring of the legs

Dark urine

Incontinence

Irregular breathing

Chest congestion, "death rattle"

Glassy unfocused eyes

When possible, the professional caregiver will be nearby and provide private time for the patient and the family to be together in the last moments and as long as possible after death. The caregiver provides comfort and support to the family as long as necessary at this crucial time.

Linda W. Olivet

See also Bereavement, Grief, and Mourning; End-of-Life Decision Making: Hospice, Contemporary; Palliative Care

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Terminal Illness and Imminent Death

The time of terminal illness and imminent death is almost always an exceptionally difficult period, both for the patient and for the family and friends. It was not always like that in the past. As recently as a century ago, dying was commonly regarded as a simple fact of existence, and the end of life was usually treated more pragmatically, often

stoically. Currently, the prospect of dying looms large and terrifying, and much of that is due to the fact that our society is emerging from a long period, perhaps five decades or more, of denying the universality of death, and of making it a taboo subject—an action that has deprived most people of any opportunity to build and strengthen preparatory and coping strategies that they might otherwise have developed.

This entry provides a brief overview of the history of social attitudes toward terminal illness and the end of life—a history that materially affects our current attitudes and coping strategies. It also offers an analysis of the main factors contributing to the heavy psychological burden of imminent death and outlines some possible strategies that may enhance coping.

Denial of Death: A Brief History

There is no universally accepted measure by which we can assess a culture's attitude to death. Therefore, any description is of necessity partly subjective. However, it seems that the separation of the process of dying from the daily business of living may have accelerated—certainly in Europe and the United States—after World War II. This change in attitude may have its sociological origins in the move away from war as a solution to political problems after the massive slaughter of the two world wars. At the same time, in the late 1940s, expectations of health were dramatically raised with the advent of effective medications, particularly antibiotics, curing some infections that had previously been common causes of early death. The power of these first antibiotics heralded a wide and major change in the effectiveness of medical treatment in many common diseases, and thus raised public expectations of a longer and healthier life. By the late 1950s and early 1960s, medical successes and breakthroughs, augmented by intense media coverage, raised general expectations of cure for so many disorders that more people expected miraculous cures for most conditions, even terminal illnesses. This atmosphere of unrealistically high expectations made it more difficult for the patient and the family to accept death.

Furthermore, the process of dying became institutionalized, to some extent, and a part of the field of specialists and experts. In many urban centers, death occurred in a hospital or nursing home in over 75% of cases, and the role of family and friends in supporting the dying person became subordinate to the expertise of medical and nursing staff. There is, of course, little intrinsically wrong with that, but it did foster the perception that family and friends had no place or role at the bedside of the dying person.

Simultaneously, most lives in the developed world were being evaluated by criteria that had become more materialistic. Again, there is nothing intrinsically wrong in summing up a person's life solely by his or her wealth or success, be it artistic, social, or financial, but it does increase the difficulty of accepting the ending of life—a moment at which the person will clearly be separated from the material symbols of worth.

Another factor is the social marginalization of the sick and the elderly. Developed nations from the 1960s until recently tended to treat the sick, the elderly, the infirm, and the dying as people on the margins or fringes of society and not as part of the mainstream. Whether or not this is regarded as uncharitable and ultimately deleterious for that society as a whole, it has consistently been an observable phenomenon and is another factor that makes things difficult for seriously ill and dying patients when they are unable to contribute to society and the workforce and are consumers of health care and support.

Along with all of these factors, there was also a general re-evaluation of the role of religion. Even as recently as a century ago, religions shared similar views of a single God, of some system of divine justice, and of some form of an afterlife. Even though religions clearly had major differences of opinion and often waged major wars against each other, the somewhat monolithic view of a God and heaven was a form of support that chaplains and priests could easily use to support the dying person. Although that support still occurs, it is less common, and more personal and individual views of religion and spirituality make it more difficult for people who may not hold the same view to support the patient and administer comfort.

Taken together, these factors—high expectations of life and health, the "expertization" of the dying process, materialistic evaluation of a life, marginalizing of the sick and elderly, and the

repositioning of the role of religion—increased the separation of the process of dying from the daily business of living. It is that separation that underlies much of the psychological burden of dying.

Minds and Hearts

There is a difference between the rational and intellectual understanding of the ending of life, and the emotional acceptance of that fact. Most people acknowledge as a rational and intellectual concept the fact that that every human life is finite. Notwithstanding any belief that a person holds about an afterlife or a kingdom of heaven, most of us acknowledge the statement that every human biological life ends in a physical death. The problem is that while we all recognize that intellectually—as an accepted cognitive fact—most of us do not live our daily lives accepting that concept emotionally. There is a disconnect between the head and the heart, a gap between thoughts and feelings. Most of the time, that disconnect is subconscious and invisible, and does not cause any problem. However, in a terminal illness and at the imminent approach of death, that gap between the intellectual acceptance of mortality and its emotional acknowledgment as a personal event often causes problems that may become severe. Hence, in the final phase of life, a considerable problem is created by the gap between mind and heart, and a great deal can be achieved in the support of the dying person by attempting to reconcile the rational with the affect, reducing that gap and the distress it causes.

A Practical Way of Thinking About the Process of Dying

It is helpful to compare the process of dying with a journey. In the late 1960s, Elisabeth Kübler-Ross proposed that there were five stages of dying, namely denial, anger, bargaining, depression, and acceptance. Although initially widely adopted, this has been found in practice to be often unhelpful in assessing the patient's situation and in predicting future events. A more practical system has been proposed that considers the process of dying as having three stages: the beginning (acute phase), the middle (chronic stage), and the end (final stage).

The Initial Phase

As the person first realizes that terminal illness and death are not merely abstract concepts but are realities as part of the future, he or she is likely to react in the way he or she has reacted to major vicissitudes in the past. Thus, people who are commonly angry will show anger, people who often cope by using denial will use denial, and similarly with the wide array of reactions that all humans experience, such as guilt, humor, bargaining, disbelief, or displacement activities, such as undertaking a new task or project, for example. Of paramount importance is that fear is an almost universal response to the diagnosis of terminal illness. Fear and anxiety about the future are so common that it would be fair to call them normal reactions to this situation, and if a person has no anxiety at all, it would be reasonable to wonder whether they truly understand their situation.

Perhaps the most important aspect of the person's initial reaction to terminal illness and imminent death is that the reactions displayed are characteristic of the person, not of the stage of the process. The way in which a person responds tells us what kind of person they are; it does not tell us what stage the process is at.

The Chronic Phase

For the duration of the terminal illness, usually the acute reactions of the first phase become less intense. The emotions are likely to become part of the person's background state, and it is in this phase that depression is particularly likely.

The Final Phase

The final phase can legitimately be defined as acceptance of imminent death—be it overt and openly expressed or covert and not discussed openly. Some people simply do not discuss their feelings about major issues, and quite often a person may know that he or she is dying but is quite comfortable not discussing it openly.

Fears Associated With Terminal Illness

Fears about dying are multiple, and it is likely that no individual will have precisely the same list of fears in the same order. A complete catalog is probably unachievable, but the most common major fears have been summarized in the matrix (Table 1).

Table 1 Common Fears About Dying

Physical	*Psychological*	*Social*	*Spiritual*
• Pain • Nausea • Disfigurement • Disability • Other physical symptoms	• Dementia • Loss of control • Personality change • Mental incompetence • Depression • Delusions	• Irritability • Anger • Loss of good decision making • Dysfunctional relations with family • Sexual problems	• Existential • Punishment in an afterlife

Provision of Help and Support at the End of Life

Help and support for a person facing a terminal illness and imminent death can be offered more readily than most people suppose. The central objective is to acknowledge the emotions that the person is experiencing—which means listening to them and then showing that they have been observed and heard—and deal with any practical problems and pragmatic aspects of the person's situation as much as possible. These two objectives, acknowledgment of emotions and addressing practical problems, are complementary.

The most important technique in acknowledging any emotion is known as "the empathic response," and it is a technique that can be used by any willing person. It is not an inborn gift given only to a few. It comprises (a) identifying one of the emotions that the person is experiencing, such as fear, shock, disbelief, or anger, and (b) identifying the source of the emotion (which is usually the situation itself or a particular piece of bad news). Then it is important to respond in a way that shows you have made the connection between the first two responses. Empathic responses are statements in the form of: "This is really tough for you, isn't it?" or "I can see you're feeling really low" or "This must be very difficult for you." Framing an empathic response shows the patient that you have noted their feelings and what has caused them; such a response will be nonjudgmental and supportive. Only after the emotions have been acknowledged can the friend or family member address the practical issues and make realistic offers to ameliorate the situation.

Many individuals find it threatening to talk about the prospect of death and thus avoid discussion of plans and arrangements. In that situation, it is useful to discuss the future as a hypothetical situation ("What would you like to do if…"), thus maintaining a hope for the best outcome while simultaneously preparing for the worst.

The "what if" approach has been shown to be less threatening and can and should be used early in the terminal illness, long before emergencies arise. As has often been said, supporting someone in a terminal illness at the end of their life is one of the most important and valuable things that one human can do for another.

Robert Buckman

See also Awareness of Death in Open and Closed Contexts; Death, Humanistic Perspectives; Eschatology; Terminal Care

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Terrorism, Domestic

Domestic terrorism is a common description of a type of extremely violent activity against a

population for domestic political or religious purposes. There is no common precise delineation of it. It is held to be illegitimate. In the following text, the definition, significance, and justification of terrorism are discussed and examples are presented.

Definition

Although the notion of terrorism and derivative expressions, such as terrorists, are frequently used, both in professional frameworks and in daily discourse, there is no commonly accepted, adequate definition of that notion. Definitions of terrorism were abundant long before September 11, 2001, and the proclaimed War on Terror. For example, by 1988 one publication enumerated 109 different definitions of that concept.

There are several reasons for the multiplicity of definitions. First, international conventions have been formulated, signed, and often ratified, banning activities of certain types. Therefore, the notion of terrorism has been used with respect to certain types of such activity, rather than all of them. The first international convention in 1963 was on "offences and certain other acts on board aircrafts," a 1988 international convention was "for the suppression of unlawful acts against the safety of maritime navigation, a 1997 international convention "for the suppression of terrorist bombings" was related to using explosives and other lethal devices in public places, and a 2005 international convention "for the suppression of acts of nuclear terrorism" was related to nuclear reactors and power plants.

Second, new forms of activity sometimes appear that constitute cases of terrorism. Hence, the 2006 Council of Europe Convention on the Prevention of Terrorism, for example, defined the term *terrorist offense* as an offence defined under any of the international conventions on terrorism that is in force.

Third and perhaps most important, definitions of terrorism have been proposed that would exclude certain types of activity on grounds of political or ideological considerations. The notion of being a terrorist is universally understood to be pejorative. Hence, when facing a definition of terrorism in terms of certain kinds of actions or activities, attempts are often made to exclude from the definition some cases that fall under the term as defined, but involve favored parties. The 1999 United Nations General Assembly resolution 49/60, "Measures to Eliminate International Terrorism," defined terrorism in terms of "criminal acts intended or calculated to provoke a state of terror in the general public, a group of persons or particular persons for political purposes." It goes on to state that such acts are "unjustifiable, whatever the considerations of political, philosophical, ideological, racial, ethnic, religious or any other nature that may be invoked to justify them." People who hold the view that acts of the described nature are justifiable on, say, some religious grounds, will oppose that resolution and try to exclude from its application whatever they believe is religiously justifiable. The 1994 Code of Conduct for the Fight against Terrorism, adopted by the Organization of Islamic Conference, during the 7th Islamic Summit in Casablanca, Morocco, added to an ordinary depiction of terrorism a proviso with respect to the rights of people under occupation to struggle for independence and self-determination. A similar condition is mentioned in Article 3 of the 1999 African Convention on the Prevention and Combating of Terrorism, accepted by the Organization of African Unity during a meeting in Algiers, Algeria. The combination of a definition of terrorism with a restriction imposed on its application is tantamount to proposing an alternative definition of the notion.

Definitions of terrorism share the following conceptual ingredients or conditions:

1. It is a practice of violence.
2. The practice involves acts of killing and injuring people who do not jeopardize the life or health of the agents of the practice, as well as threats to perform such acts.
3. The practice is used against members of a certain population.
4. The practice is used in a regular manner.
5. The practice is used in order to terrorize that population.
6. The practice is used in order to change the political situation by means of terrorizing the population.
7. The practice is used on political, ideological, or religious grounds that justify it in the eyes of its agents.

Some definitions of terrorism include additional ingredients that are not conceptual but rather contingent. The practice of terrorism can appear in their absence.

8. The practice is used by an underground organization.

9. The practice is used against members of a certain population in a random manner.

Condition 8 is not necessary. Osama bin Laden and associates declared in their 1998 World Islamic Front Statement that jihad (the holy war or struggle) is an individual duty of Muslims. Their followers can practice terrorism without being organized as such. On the other hand, condition 8 naturally obtains when the practice involves criminal activities of certain types. Condition 9 naturally obtains when the practice of terrorism involves suicide bombers operating in public places. However, it is not a necessary ingredient of terrorism. One can imagine attempts to terrorize a population by announcing a list of places or areas to be targeted.

The previous list of conceptual ingredients of terrorism, 1 through 7, does not include an attribute that appears in many definitions. Condition 2 is couched in terms of people, victims of an act of terrorism, who do not jeopardize the life or health of the agents of the act. Often, a similar condition employs the distinction between combatants and noncombatants, familiar from the Just War Doctrine and international laws of armed conflicts. Condition 2 is not phrased in terms of noncombatant victims because acts of terrorism can take place outside the confines of a war between military forces, including guerrilla units, and still be directed against people in military uniform, where all the other conditions also obtain.

The definition of terrorism to be used here allows practices of a local nature and practices of an international nature. In the former case, the political change sought by practicing terrorism is of a local nature and usually the victims and the population to which they belong are locally identifiable. In the latter case, both the ends and the means are of a broader nature. The present entry is related to the former type of terrorism.

Justification

Acts of local terrorism are never morally, legally, or religiously justifiable. A performed act of terrorism involves agents of the practice of terrorism killing or injuring the victims of the practice. The victims do not jeopardize the life or health of the agents. The act of terrorism is not an act of self-defense, in any reasonable sense of the term. Killing children, because eventually they will serve as conscripts who often do jeopardize the life or health of people, is not self-defense. Nor is any instance of killing people because they are compatriots of people who do often or even presently jeopardize the life or health of people.

Thus, the victims of the practice of terrorism are merely used by the agents of the practice in order to terrorize people and thereby cause a certain political change. Using human beings as a mere means in the pursuit of an end, be it personal, political, religious, or any other reason, is morally wrong. It is incompatible with the duty to respect the human dignity of the people who are the victims of the practice of terrorism. It utterly blurs the distinction between human beings and tools (for information relating to common attempts to justify acts of terrorism on grounds of the fact that their agents are freedom fighters, see the "Terrorism, International" entry).

Consequentialist considerations might suggest delineation of certain extreme conditions that, if obtained, would justify terrorism of some form. However, it has been shown that such conditions are never obtained, and therefore terrorism is never justified in practice, not only on deontological grounds but also on consequentialist ones.

Within the framework of any legal system, acts of terrorism are legally unjustifiable and obviously criminal. The reasons for it could vary, from democratic regimes that are interested in human rights as part of respect for human dignity to nondemocratic regimes that are interested in power and stability. The criminal nature of acts of terrorism remains the same.

Some religions, such as Jainism, and some denominations, such as the Quakers, Amish, and Mennonites, are pacifist. Others have at least some pacifist inclination. From the traditional religious point of view, the practice of terrorism is always utterly wrong. From the point of view of other religions and denominations, the practice of domestic

terrorism is sinful and forbidden. However, movements within religious frameworks, even if usually marginal, have resorted to the practice of terrorism.

Meaning

Historical examples of terrorism manifested the unscrupulous pursuit of collective goals, which involved inflicting death and injury on numerous people. Under these historical circumstances, causing death was naturally regarded as the extreme form of harming people. The prospects of the victims being considered martyrs or even beatified did not give rise to compelling arguments against usage of the practice of terrorism. A person will never be grateful to enemies for rendering a child, spouse, sibling, or compatriot as a martyr now residing in paradise. This insight into the core of human attitudes toward the death of beloved ones was shared by all parties to the same conflict.

The phenomenon of suicide bombers involves another attitude toward death of the beloved. Many agents of the practice of this form of terrorism left behind records that implied a distinction between a culture that abhors death and a culture that does not. Some relatives of these agents expressed pride and admiration for their acts. However, praising the suicide bombers has never eliminated grieving their death and employing the common practices of mourning and bereavement. The alleged cultural distinction has not been convincingly shown to exist.

Examples

India

The ethnic, religious, linguistic, and political differences between populations within the Indian subcontinent have given rise to a variety of conflicts. Two major foci of conflict involved resort to the practice of terrorism: Kashmir and Punjab. The conflict related to the former reflects certain Hindu-Muslim relationships, while the conflict related to the latter reflects aspects of the Hindu-Sikh relationships.

The two cases involve the pursuit of political changes of different kinds. Groups that used the practice of terrorism in the context of Kashmir, such as Jamma, pursue politically extreme goals of independence or even union with Pakistan. While some Sikh groups that resorted to the practice of terrorism, such as Dashmesh, have acted in pursuit of an independent Sikh Khalistan, other groups hoped to achieve politically enforceable, religiously motivated arrangements with respect to the Sikh temples and a ban on the sale of liquor and tobacco. Whereas the latter pursuit has had some successful results, the former one has not become closer to any acceptable solution.

Ireland

Centuries of conflict over Northern Ireland manifested numerous usages of the practice of terrorism on grounds of national, religious, historical, and linguistic differences. On the Irish Catholic side of the border, Sinn Fein, a political party that had a military branch known since 1924 as the Irish Republican Army (IRA), used the practice of terrorism in Northern Ireland. In 1969, a split took place, and the Provisional IRA (PIRA) was created. The PIRA was involved in many acts of terrorism and assassination. On the Protestant side of the border, the Ulster Volunteer Force, active since 1912, committed acts of terrorism in public places related to the IRA and its supporters.

The case of Northern Ireland is of particular interest because in the late 1990s it reached stages of ceasefire, of cessation of terrorism and guerrilla activities, and even of a political agreement that would lead to lasting peace. However, small groups that might resort to the practice of terrorism still exist on both sides of the border.

Asa Kasher

See also Assassination; Death, Humanistic Perspectives; Legalities of Death; Martyrs and Martyrdom; Massacres; Terrorism, International

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Terrorism, International

International terrorism is the phenomenon of extremely violent activities against a population for political or religious purposes that are not related to a specific domestic conflict in particular, but rather to some struggle of a global nature. In this entry, the definition, significance, and justification of international terrorism are discussed and measures that have been taken against it are presented.

Definition

The notion of international terrorism is used in two different senses. In a narrow sense, international terrorism is a special form of domestic terrorism. Consider the following elements of terrorism in general:

- It is a practice of violence.
- The practice involves acts of killing and injuring people who do not jeopardize the life or health of the agents of the practice, as well as threats to perform such acts.
- The practice is used against members of a certain population.
- The practice is used in a regular manner.
- The practice is used in order to terrorize that population.
- The practice is used in order to change the political situation by means of terrorizing the population.
- The practice is used on political, ideological, or religious grounds that justify it in the eyes of its agents.

In domestic terrorism, the purpose of the practice of violence is to change the political situation of a certain state. The means of terrorizing the population of that state are by the killing or injuring of members of that population. Thus, the purpose, the terrorized population, and the victims are all of a domestic nature. However, sometimes one or more of these domestic elements take a form that extends beyond the confines of a single state and population. Activities of terrorism can be related to a region that overlaps a number of states. Attempts to terrorize the population of a nation-state can involve killing people of the same nation but not of the same state. Such activities are often described as cases of transnational terrorism.

International terrorism in the broad sense is not a special form of domestic terrorism, but rather a different kind of terrorism. The purpose of resorting to the practice of violence is not related to any state or some adjacent states in particular, but is global in nature. The intended targets of terrorism are not those of a certain state or nation, but are of a much broader nature, such as members of a certain civilization. Consequently, the intended victims are also members of a broadly and vaguely delineated group of people. In the following text, international terrorism in the broad sense of the term is discussed.

Significance

The phenomenon of international terrorism has changed the role of death in the life of numerous people in numerous areas on the globe in two fundamental ways. First, the constant state of personal insecurity has become widespread. Given ideal conditions of eternal peace, no human being's life is constantly under jeopardy. In ordinary conditions that do not involve terrorism of any kind, most human beings are members of groups that are immune from military or similar enemy attacks. Under conditions of domestic terrorism, human beings who are not involved in the domestic conflict and reside away from the territory of the conflict usually do not have to face daily insecurity. However, when conditions of international terrorism obtain, human beings who do not consider themselves parties to any global conflict, because they are not responsible in any significant way for what caused the conflict or what has happened or is about to happen within its global framework, are constantly jeopardized.

The resulting sense of personal insecurity is deepened by the random element of many activities of terrorism. When a suicide/homicide bomber explodes in a mall, nothing in his or her planned

action need be related to the particular time, place, or dozens of victims. Any other time, place, and dozens of victims would be of the same value, from the point of view of the terrorist. Randomness enhances insecurity.

Second, some ideological and religious grounds on which activities of international terrorism are justified in the eyes of their perpetrators have undergone processes of privatization. Following Sayyid Qutb, the intellectual father of Muslim radicalism, Abdullah Azzam, the teacher of Osama bin Laden, preached global jihad in which Muslims shoulder individual responsibility for defending the community of Muslims from its enemies. A slogan ascribed to him is "Jihad and rifle alone." Thus, according to Azzam's view, it was a personal duty of a Muslim to struggle against the presence of the Soviet Union in Afghanistan. Although just a small minority of the Muslims have adopted, let alone practiced, Azzam's way, an atmosphere that nurtures individual acts of terrorism, of spreading death anytime, anywhere, indiscriminately, has become more than a mere theological possibility.

Justification

Actions of terrorism, whether domestic, transnational, or international, are generally regarded as illegitimate, from any moral, ethical, or legal point of view. Even those philosophical theories that set conditions under which some action of terrorism is considered justified have no practical consequence because the conditions they set are never obtained.

In public and political discourses, which usually do not excel in philosophical subtlety or moral, ethical, and legal responsibility, the most prevalent justification of some forms of terrorism is the slogan "one person's terrorist is another person's freedom fighter." Common usages of that slogan are meant to exempt an agent of a terrorist act from moral responsibility for having committed an atrocity on grounds of the terrorist's attempted justification of the atrocity in terms of his or her doing it as a freedom fighter.

Such an exemption of the agent of an act of terrorism from being morally blamed for having committed an atrocity is never warranted. Freedom fighting, in the ordinary sense of the term, is related to domestic or transnational conflicts, not to global conflicts of an ideological or religious nature. Hence, generally speaking, international terrorism cannot be justified on grounds of its being a strategy of freedom fighting.

More importantly, assuming that international terrorism is on a par with domestic terrorism and transnational terrorism being directly related to some form of freedom fighting, it would still not follow that such acts are thereby, and for that reason, exempt from moral or ethical evaluation or blame.

Underlying the slogan are three conceptual mistakes. First, it rests on a confusion of end evaluation and means evaluation. Acts of terrorism are means. Theoretically, they can be used in pursuit of different ends, both evil ones and good ones. Moral condemnations of terrorism are evaluations of the means people use in pursuit of their ends, independent of the nature of these ends, which are going to be separately evaluated from a moral point of view. Actions of terrorism should never be carried out, never be used as means in a pursuit of any end whatsoever.

An objection can be raised here against the insistence on moral evaluation of the means independent of any moral evaluation of the ends. Are not rational beings required to use means that are effective, that is, means that enable the achievement of the goals, either fully or at least to the best extent possible under the circumstances?

Here is where the second conceptual mistake is made. Although evaluations of instrumental rationality have to do with ends and means relationships, moral evaluations of actions can be made independently of the ends agents had in mind when these actions were planned or carried out. Actions of violence against children as such are always evil. One does not have to be informed about the point of such violence in order to evaluate it from a moral point of view.

At this point yet another objection can be raised. Why shouldn't there be a distinction between ordinary ends and supreme ones, where the latter but not the former sanctify, so to speak, ends used in its pursuit? On the background of such a general distinction, freedom fighting will be naturally regarded as a supreme end that justifies every action performed in its service, including actions of terrorism. However, such a line of argument runs afoul of basic moral intuitions. Would the supreme end of freedom justify genocide? No moral theory would answer this question in the affirmative.

Protection of human life and dignity in general is also a supreme end, and there is no reason to assume that the supreme ends allegedly served by actions of terrorism are more important.

Fighting Terrorism

Three methods of opposing terrorism have been used in the struggle against international terrorism. The end of all of them has been self-defense in the deepest sense of not only preventing activities of international terrorism but also eliminating its threat.

The first method involves intelligence, military, police, and similar activities. To a large extent, international terrorism rests on networks of groups that carry out related actions. Such networks have crucial elements that should be destroyed or significantly weakened in order to preempt imminent activities and prevent possible future activities of international terrorism. The military operations of the United States and NATO against the Taliban in Afghanistan after the al-Qaeda terrorist actions of September 11, 2001, are the most conspicuous application of the first method.

Casualties abound in such military operations, among the troops, noncombatants who reside near the terrorists (collateral damage), and the terrorists. All of them are additional victims of international terrorism.

Activities of home security often involve restrictions on the extent to which citizens may exercise their civil liberties and human rights. Flight security, as manifest in airports, is an example. These restrictions introduce the struggle against international terrorism into daily routine, thereby introducing the idea of death threats into spheres of ordinary life.

The second method of opposing terrorism is that of international law. International conventions on terrorism have been signed and ratified since 1973 (when a UN Convention on the Prevention and Punishment of Crimes against Internationally Protected Persons, including Diplomatic Agents, was adopted by the General Assembly). Introduction of additional conventions took place most intensively during the late 1990s, within the framework of the United Nations, Council of Europe, Organization of American States, Organization of African Unity, and others. Each of the conventions was directed against a certain aspect of terrorism.

Most recent is the UN International Convention for the Suppression of Acts of Nuclear Terrorism, which took place in New York on April 13, 2005. Article 6 of the convention typically requires that each state party adopt appropriate measures "to ensure that criminal acts . . . in particular where they are intended or calculated to provoke a state of terror in the general public or in a group of persons or particular persons, are under no circumstances justifiable by considerations of a political, philosophical, ideological, racial, ethnic, religious or other similar nature and are punished by penalties consistent with their grave nature."

The third method is much less organized but not of the least importance. An activity within the framework of the third method takes the form of educational and other public activities, carried out by people who share with agents of international terrorism their religion or denomination, language, or parts of a culture, and even kinship relationships, but nevertheless oppose international terrorism, both in general and with respect to particular terrorist actions. It may be assumed that the third method provides the best means for a long-range uprooting of international terrorism.

Asa Kasher

See also Death, Humanistic Perspectives; Legalities of Death; Terrorism, Domestic

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Terror Management Theory

Terror management theory (TMT) is a prominent theory in social psychology that holds the idea that basic motivation for human cognition and behavior is the fear of death. Based on Ernest Becker's ideas regarding human motivation, TMT was generated and published in the late 1980s by Jeff Greenberg, Tom Pyszczynski, and Sheldon Solomon, and centers around the psychological mechanisms typically used to buffer the anxiety deriving from the awareness of one's own death. The authors assert that in order to avoid the feelings of helplessness and terror aroused by the knowledge of the inevitability of death, human beings have developed psychological mechanisms that help eliminate such thoughts from their consciousness. These symbolic defenses are conceptualized as a dual-process model of proximal and distal defenses, whereby proximal defenses consist of attempts to suppress thoughts of death, while distal defenses address the issue of death in a symbolic manner by modifying perceptions of the self and the world.

Most of the empirical work on TMT thus far has focused on two types of distal defenses. The first is based on validating one's *cultural worldview,* thereby providing a set of standards for values and behavior, as well as the promise of transcending death. The second is intended to increase *self-esteem* by living up to the standards prescribed by the culture. In other words, people are motivated to maintain faith in their cultural worldviews and satisfy the standards associated with these worldviews.

Accordingly, TMT has given rise to the *mortality salience hypothesis,* which holds that individuals exposed to reminders of death react positively to ideas and people that support and validate their cultural worldview, and they react negatively to ideas and people that deviate from it. Similarly, mortality salience is expected to lead to cognitive and behavioral efforts toward maintaining or enhancing self-esteem. This hypothesis has received extensive empirical support. In most studies, mortality salience is manipulated by using two open-ended questions: "Please briefly describe the emotions that the thought of your own death arouses in you" and "Jot down, as specifically as you can, what you think will happen to you as you physically die." Other mortality salience manipulations have included proximity to a cemetery, films evoking thoughts of death, death anxiety scales, and exposure to subliminal primes of death-related words.

Research has shown that mortality salience leads people to oppose and even act aggressively toward others on the basis of political, religious, national, moral, and ideological differences, as well as to commend those who uphold their cultural values, such as turning a criminal in to the police. After exposure to a mortality salience induction, participants are also more willing to donate to charity, particularly charities that benefit their ingroup, indicate higher motivation to enlist in the army, and even show a tendency to sit closer to an ingroup than an outgroup member.

Moreover, several studies have found that awareness of death evokes a diverse set of both adaptive and maladaptive responses through which individuals seek to protect themselves from conscious and unconscious death-related cognition. Hence, some studies have found that in order to preserve or validate their self-esteem following a mortality salience induction, participants show higher intentions of keeping fit and other manifestations of positive health behavior, while other studies report a greater willingness to take risks, such driving recklessly and engaging in unsafe sex, along with the denial of vulnerability to health risks. The reactions were most often found to relate to the degree of the relevance of each behavior to the individual's self-esteem.

Another hypothesis deriving from TMT is *self-esteem as anxiety buffer,* which proposes that if self-esteem serves to buffer anxiety, then high self-esteem (either as a dispositional trait or following an experimental manipulation) should reduce the anxiety aroused by real or symbolic threats. Empirical evidence supports this hypothesis, indicating that momentary elevation of the sense of self-esteem or a dispositional tendency for higher self-esteem reduces both physiological arousal and self-reported anxiety in response to a variety of threats.

It has recently been suggested that close relationships may also serve the terror management function of buffering the fear of death. A series of studies has shown death reminders lead to a higher desire for intimacy in romantic relationships,

greater willingness to initiate social interactions, lower rejection sensitivity, and more positive appraisals of interpersonal competence. These effects were found mainly among individuals characterized as high in attachment security, which is considered an emotional regulation device. Moreover, thoughts about sustained or irreversible separation from a close partner led to a higher accessibility of death-related thoughts than thoughts about other kinds of separation, particularly among people scoring high on attachment anxiety. These studies suggest that a mortality salience induction might prompt people to seek proximity in a wide range of interpersonal situations, while thoughts of long-term separation issues might elicit more death-related thoughts.

Empirical work on TMT is continuing. Recent studies have produced evidence of the effect of exposure to awareness of death on various aspects of life, including maternal separation anxiety, breast-feeding, decision making, psychopathology, religiousness and spirituality, and coping with terrorism.

Orit Taubman–Ben-Ari

See also Death, Clinical Perspectives; Death, Psychological Perspectives; Death Anxiety

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THANATOLOGY

The *Oxford English Dictionary* defines thanatology as "the scientific study of death, its causes and phenomena." Also (U.S. origin), "the study of the effects of approaching death and of the needs of the terminally ill and their families." The word thanatology first appeared in 1842 in a British medical lexicon. By the mid-1970s, thanatology was recognized as a special area of study, and Lawrence Stone referred to thanatology in a 1977 book review of *Growing Old in America* as a special branch of learning exemplified by historians of death, like Philippe Aries and Michel Vovelle, who have promoted the topic.

Background for the Concept: A Multidisciplinary Approach

A pioneer within this special branch of learning was Herman Feifel, whose books created an opening for scholarly discussions and reflections on topics such as death anxiety, terminal illness, hospice and palliative care, and the impact of death on survivors. Another pioneer was Elisabeth Kübler-Ross, whose work with terminally ill people in a Chicago hospital led her to advocate that these patients be seen as human beings deserving dignity. Kübler-Ross created a framework called stages of dying for understanding emotional responses of the terminally ill. Although empirical research has not confirmed Kübler-Ross's stages of dying and clinicians have expressed deep skepticism of the applicability of her ideas, the popularity of her views has not diminished.

While Feifel and Kübler-Ross were pioneers in the psychological aspects of thanatology, other pioneers have shaped our contemporary experiences and understanding of death, dying, and bereavement. In the sociological arena, important contributions were made during the 1960s by psychiatrist Edwin Shneidman, whose work increased the awareness of the complexity of suicide, while Barney Glaser's and Anselm Strauss's qualitative research into responses to death within hospitals gave us new concepts, such as modes of awareness of dying and dying trajectories. In the mid-1960s, sociologist Robert Fulton examined the linkages between death and identity. Then, in the early

1970s, Ernest Becker wrote his influential book, *The Denial of Death*. And in the first years of the 21st century, the Center for the Advancement of Health convened an interdisciplinary group of thanatology scholars who produced a lengthy article that examined research on bereavement and grief and an article examining efforts to bridge the gap separating thanatology practitioners and researchers.

Education about thanatology burgeoned in the 1970s and continued thereafter, leading to two historical interpretations in 1977 and 1986, a 2004 analysis of 30 years of death education in the schools, and a 2007 examination of the state of thanatological education. In 1970, Robert Kastenbaum founded the journal *Omega*. Other peer-reviewed journals followed: *Death Studies* (originally *Death Education*) in 1977, *Journal of Palliative Care* in 1985, *Illness, Crisis, and Loss* in 1991, and *Mortality* in 1996. Since the 1970s, colleges and universities established courses on death, dying, and bereavement, textbooks on these topics were published, and far-right ideologues initiated a backlash against death education.

Hospice and Palliative Care

Perhaps the most profound influence upon thanatology in the 20th century was the growth of the hospice movement and of palliative medicine. Two figures prominent in this medical advance were Cicely Saunders, the founder of the modern hospice movement, and Balfour Mount, a Canadian physician who championed the practice of palliative medicine with people whose terminal illness was beyond treatment. In consort with Kübler-Ross's dogged perseverance on treating dying patients as persons, their insistence that the dying individual is a living human person who deserves respect and dignity has become the credo in thanatology.

Because dying and bereavement affect people physically, emotionally, cognitively, socially, behaviorally, and spiritually, thanatological care requires the coordinated efforts of interdisciplinary teams. Empirical research with both the dying and with the bereaved confirms this holistic aspect to thanatology. Interdisciplinary teams are available to address the multiple forms pain takes: somatic pain, whether acute (e.g., a toothache) or chronic (e.g., the endemic pain of bone cancer); emotional pain (fear about dying alone); behavioral pain (such as regrets at loss of normal activities due to the disabling effects of a disease); cognitive pain (e.g., distress at increasingly failing memory and problems concentrating); social pain (e.g., loneliness at isolation from friends and family); and spiritual pain (anxiety at having been abandoned by God, inability to find any meaning in one's predicament, and personal insignificance in the vast universe).

The Crucial Influence of a Professional Organization

The Association for Death Education and Counseling (ADEC), an interdisciplinary organization in the areas of death, dying, and bereavement, titles itself The Thanatology Association. The ADEC's influence on thanatological research and practice includes many examples. For instance, it has developed and administers a three-hour exam to certify mastery of knowledge deemed fundamental to thanatology. The ADEC sponsors symposia at annual conferences on research that matters to practitioners, offers continuing education on many topics, hosts special interest groups on such subjects as AIDS education and bridging research and practice, and has developed a database to enable people to locate and contact a thanatologist.

Operationalizing Concepts That Serve as the Basis for Study

The ADEC has addressed the complexity and scope of thanatology by identifying six categories fundamental to thanatology research and study by offering operational definitions for each of these categories, thereby giving structure and organization to this growing and influential area of analysis.

1. *Dying:* the physical, psychosocial, and spiritual experience of facing death, living with terminal illness, and caring for the terminally ill.
2. *End-of-life decision making:* the aspects of life-threatening illness/terminal illness that involve choices and decisions about actions to be taken, for individuals, families, and professional caregivers.

3. *Loss, grief, and mourning:* the physical, behavioral, cognitive, and social experience of and reactions to loss, the grief process, and practices surrounding grief and commemoration.
4. *Assessment and intervention:* information gathered, decisions that are made, and actions that are taken by professional caregivers to determine and provide for the needs of the dying, their loved ones, and the bereaved.
5. *Traumatic death:* sudden, violent, inflicted and/or intentional death, shocking encounters with death.
6. *Death education:* formal and informal methods for acquiring and disseminating knowledge about death, dying, and bereavement.

The ADEC recognizes that each of the six thanatological categories is embedded in structural features termed "indicators." Ten indicators have been identified to date:

1. *Cultural/socialization,* which refers to the impact on death and bereavement of culture and socialization (including ethnicity). An example is the influence of ethnic group membership on advance care planning in end-of-life decision making. Another example is social inhibitors to health care.
2. *Religious/spiritual,* which refers to the interactive relationship between belief systems (including spirituality) on reactions to and coping with death and bereavement. An example is how religious and spiritual belief systems understand the place of suffering and views on a life after death. Another example is curriculum aimed at training clergy in matters of death, dying, and bereavement.
3. *Historical,* which refers to changes over time and context that influence how people experience and understand death and bereavement, as well as theories pre-1980 informing scholars about these matters. An example is the scholarly work of Phillip Aries that identified dominant patterns in the Western world toward death. Another example is the earlier scholarship of Sigmund Freud regarding coping with bereavement.
4. *Contemporary,* which refers to post-1980 theoretical viewpoints in thanatology as well as influences on these viewpoints. An example is the emergence of attention toward complicated grief, now referred to as prolonged grief disorder. Another example is scholarship on continuing bonds.
5. *Life span,* which refers to changes over the life span from infancy through old age that involve death, dying, and bereavement. An example is attention to influences on suicide as people change over time. Another example is developmentally appropriate language when discussing thanatology topics with children.
6. *Larger systems,* which refers to systemic influences in society that affect how individuals and families experience death, dying, and bereavement. An example is the growth and development of the biomedical model; another example is the emergence of support groups for bereaved parents.
7. *Family and individual,* which refers to encounters with death, dying, and bereavement from the vantage point of the person and of "the group of people with a relational bond and long term commitment who define themselves as 'family'" (Balk, Wogrin, Thornton, & Meagher, 2007, p. ix). Caregiver issues and gender issues in care of the dying provide examples.
8. *Resources,* which refers to materials and other sources of information that aid in acquiring knowledge about thanatology matters. Books written to help children understand death, dying, and grief serve as one example, as do major national organizations, such as Mothers against Drunk Driving (MADD) and ADEC.
9. *Ethical/legal,* which stands for principles for determining right from wrong in matters of death, dying, and bereavement, as well as laws established that pertain to death, dying, and bereavement. Examples include criteria for the determination of death and workplace bereavement policies.
10. *Professional issues,* which refers to features influencing the preparation, skills, and responsibilities of professionals facing thanatology situations. An example is certification of knowledge and training about bereavement. Another example is recognizing the differences between grief counseling and grief therapy.

Conclusion

In contemporary conversations occasionally one hears dissatisfaction with the term *thanatology.* The dissatisfaction centers on the term's complexity and on its unfamiliarity to many people. No single other term is offered as an alternative, but rather suggestions are for a phrase such as "death, dying, and bereavement." Responses in favor of the term *thanatology* include (a) the term concisely expresses the scope and breadth of the field; (b) the term known across several disciplines; (c) ADEC, the major professional association in the field, has chosen the term *thanatology* to declare its focus; and (d) many complex and initially unfamiliar terms, particularly in biomedicine, identify fields of endeavor. Examples include oncology, ophthalmology, and endocrinology.

In 1977, Vanderlyn Pine maintained that thanatology had gone through three temporal changes: an era of exploration (1928–1957), a decade of development (1958–1967), and a period of popularity (1968–1977). In 1986, he examined 1976 through 1985, which he deemed thanatology's age of maturity. Since 1985 so many occurrences have shaped thanatology that in hindsight it seems premature to consider that the field reached maturity by 1985. The emergent voice of the ADEC, the convergence of practitioners and researchers to bridge the gap separating them, the merger of neuroscience and bereavement research, and the top-notch work in palliative medicine and in bereavement research published since 1985 suggest the age of maturity was a prelude to increased vigor.

Numerous issues capture the imagination of thanatologists and are directing the current and future work in the field. By definition, issues both engage people and lead them to disagree. Advances occur in the creative dynamics of dealing with issues dividing a field. Consider these issues that engage and divide thanatologists, (a) the human person's autonomy implies the right to die with dignity even if that means suicide or euthanasia, (b) grief counseling efforts sometimes benefit the normally bereaved but often harm them, (c) complicated bereavement merits its own psychiatric diagnosis, (d) continuing bonds is both the typical and expected response when coping with the death of a loved one, and (e) people never recover from bereavement.

David Balk

See also Death Anxiety; Denial of Death; Hospice, History of; Kübler-Ross's Stages of Dying; Palliative Care; Suicide

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Tibetan Book of Living and Dying, The

Sogyal Rinpoche's 1992 publication, *The Tibetan Book of Living and Dying,* is a work partly based upon the Tibetan Buddhist text *Bardo Thödol,* or *Tibetan Book of the Dead.* Sogyal Rinpoche's text interprets and expands upon many of the teachings in the *Bardo Thödol* and includes personal stories of struggles with death, dying, and grief in the 20th century. This entry overviews the book's content.

Content

The four main parts, "Living," "Dying," "Death and Rebirth," and a "Conclusion," of the 425-page

book explain Sogyal Rinpoche's interpretations of the *Bardo Thödol* and offer advice in the style of many popular psychology works on coping with caregiving, death, and the dying process. Details of translations from the *Bardo Thödol* are not provided in *The Tibetan Book of Living and Dying*. Sogyal Rinpoche explains basic assumptions within the Buddhist view of reality, including karma, rebirth, the impermanence of all things, and meditation as a means to liberation from the repeated cycle of rebirth and death. Particularly Tibetan Buddhist beliefs are also explained, including the concept of *bardol* (or in-between states) experienced immediately after the time of death, between one life and rebirth in the next. Each of the book's parts is punctuated with accounts of individuals struggling with terminal diseases, grief, or suffering in general. Sogyal Rinpoche often draws parallels between Buddhist and Christian concepts, such as compassion, patience, and the Buddha and Jesus as great teachers, suggesting that the book is meant primarily for Western audiences. Sogyal Rinpoche also draws upon Western poets such as Rainer Maria Rilke, William Blake, and Percy Bysshe Shelley to further establish commonalities between Buddhist and Western epistemologies and modes of contemplation, as well as contemporary scholars and authors such as Elisabeth Kübler-Ross and Cicely Saunders for foundational theories of grieving processes and caregiving advice. A portion of the book's Part Three on "Death and Rebirth" interprets near death experiences (NDEs) in Buddhist terms, referencing the *Bardo Thödol* in detail to argue that NDEs are accepted in the Tibetan Buddhist worldview as valid accounts of what happens in *bardo* existences. *The Tibetan Book of Living and Dying* also contains four appendices, "My Teachers," "Questions About Death," "Two Stories," and "Two Mantras." These sections address contemporary questions about Buddhist attitudes toward such issues as suicide, abortion, and organ donation; provide further personal stories, such as those of an English cancer patient and an American man with AIDS coping with pain; and offer meditative prescriptions for the dying or grieving.

The 1992 publication begins with a brief Foreword by Tenzin Gyatso, His Holiness the 14th Dalai Lama, who emphasizes the importance of a meditative and virtuous state of mind for a good life and a good death, both defined as opportunities for enlightenment.

Bardo Existences

The Tibetan Book of Living and Dying is partly based on the *Bardo Thödol,* perhaps best translated as "Liberation Through Hearing," a reference to the opportunities presented in the bardo stages for liberation from *samsara,* the world of birth, death, and rebirth. The text is popularly known in English as the *Tibetan Book of the Dead.* The Tibetan Buddhist sacred scripture is attributed to Padmasambhava, the 8th-century yogin, and contains deeply rich symbolism often characteristic of the Vajrayāna school of Buddhism. It teaches, in agreement with all Buddhist schools, that there is no self or soul, and desires attached to the imagined self must be overcome in order to achieve release from endless rebirths. According to the *Bardo Thödol,* the period of 49 days, divided into three states or stages, from the moment of death and after is a time in which the deceased will either find liberation or reenter samsara. The words of the *Bardo Thödol* are both explicit instruction and comfort through this passage. In the *Chikhai Bardo* (or "moment of death" state), consciousness separates from the body. In the *Chönyid Bardo* (or state of experiencing "supreme reality"), powerful visions caused by one's own illusions of ego appear. The person must conquer the projected images as representations of his or her own desires. Finally, in the *Sidpa Bardo* (or "becoming" state), the person is drawn to samsara, and the chances for liberation are greatly decreased. The deceased is "becoming" again and searches for a body. It is these three stages of existence that form the basis for Sogyal Rinpoche's discussions and commentaries on death, dying, and the ideal life.

Eve L. Mullen

See also Buddhist Beliefs and Traditions; Christian Beliefs and Traditions

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Tobacco Use

Tobacco is a legal product that kills 1,200 people each day, and ultimately half of its long-term users. It contains more than 5,000 toxins and chemicals, including more than 60 cancer-causing chemicals. This product is also highly addictive, making it difficult for users to quit. Despite its lethality, this product is unregulated, widely marketed, and readily available. This entry outlines the myriad of diseases caused by tobacco and provides a review of interventions that could eliminate these preventable deaths.

Trends in Tobacco Use

Adult smoking prevalence in the United States decreased from 42% in 1965 to 21% in 2004. Progress then slowed, and prevalence remained at 21% from 2004 to 2006. In 2006, 45 million Americans smoked. Prevalence was higher for men (24%) than for women (18%) and higher among those 18 to 44 years of age (24%). Smoking prevalence was 10% among Asians, 15% among Hispanics, 22% among whites, 23% among blacks, and 32% among American Indians and Alaska Natives. Smoking was highest among people with 9 to 11 years of education (35%) and lowest for people with 16 or more years of education (<10%). Smoking prevalence was also higher for people living below the poverty level (31%) than for those living above that level (20%). Despite these differences, however, the demographics of smokers still largely reflects the demographics of the U.S. population (white, 12 or more years of education, and half living at >2.5 times the poverty level).

Death by Tobacco Use

Tobacco use is the leading preventable cause of death in the United States. Cigarette smoking causes more than 400,000 deaths each year, which is 18% of all deaths in the United States. Half of all smokers' deaths occur in middle age, and people who die from smoking lose, on average, 14 years of life. Each year, smoking costs $96 billion in health care costs, $97 billion in productivity losses from premature deaths (but excluding productivity costs due to illness), and $10 billion in health care costs and productivity losses from exposure to secondhand smoke. The cost burden to the smoker and his or her family, as well as the costs to society, totals $220,000 for male smokers and $106,000 for female smokers, the equivalent of $40 per pack of cigarettes.

Death From Cancer

Cigarette smoking causes many cancers, including cancers of the lip, mouth, pharynx, esophagus, stomach, pancreas, larynx, trachea, lung, cervix, kidney, bladder, and acute myeloid leukemia. Cigar smoking causes cancer of the mouth, esophagus, larynx, and lung, and may increase the risk of pancreatic, bladder, and colon cancer. Pipe smoking causes lip cancer and is also associated with cancers of the mouth, pharynx, larynx, esophagus, and lung; and there may also be an increased risk of colon, rectal, pancreas, and bladder cancer. Secondhand smoke (SHS) causes lung cancer. Smokeless tobacco causes oral and pancreatic cancer, and may increase the risk for cancers of the stomach and esophagus.

Tobacco smoke contains nearly 5,000 chemicals, including more than 60 chemicals known to cause cancer. Chemical analysis shows that cancer-causing agents are found at comparable levels in the smoke from pipes, cigars, and cigarettes. More than 50 cancer-causing chemicals have been identified in SHS, which is classified as a known human carcinogen. In fact, many carcinogens are found in even higher concentration in SHS than in mainstream smoke. The levels of cancer-causing agents in smokeless tobacco are often at levels hundreds of times higher than the legal limit for foods and beverages.

Death From Heart Disease

Cigarette smoking causes cardiovascular diseases, including coronary heart disease (CHD), atherosclerosis, abdominal aortic aneurysm, and stroke. Cigar smokers who inhale and pipe smokers are at

increased risk for CHD. Exposure to SHS also causes heart disease. In addition, some studies have reported a higher risk of cardiovascular diseases and other complications, such as hypertension, CHD, stroke, diabetes, hypercholesterolemia, and abnormal lipid levels, with smokeless tobacco use.

Death From Respiratory Diseases

Tobacco smoke injures the airways and the lungs. Smoking causes respiratory problems, including chronic obstructive pulmonary disease (COPD, such as chronic bronchitis and emphysema); pneumonia; early onset and a faster age-related decline in lung function; respiratory symptoms such as cough, phlegm, wheezing, and shortness of breath; and poor asthma control. Cigar and pipe smokers are also at increased risk for COPD. SHS exposure causes reduced lung function, pneumonia, bronchitis, recurrent ear infections, cough, phlegm, wheezing, breathlessness, and more severe asthma attacks.

Pregnancy-Related Complications and Infant Death

Smoking before and during pregnancy causes reduced fertility, fetal death, stillbirth, low birth weight infants, pregnancy complications, and sudden infant death syndrome (SIDS). Exposure to SHS also causes lower birth weight infants and SIDS. Adverse pregnancy outcomes have also been reported from smokeless tobacco use.

Tobacco Addiction

Tobacco is highly addictive. When smoke is inhaled, nicotine is absorbed into the arteries and reaches the brain within 10 seconds. Recent research suggests that addiction may start to occur as early as the first few cigarettes. The nicotine in cigar smoke and smokeless tobacco is easily absorbed through the mouth.

Nicotine causes both stimulant and depressive effects. Stopping tobacco use results in withdrawal symptoms, including craving for nicotine, irritability, frustration, anger, anxiety, difficulty concentrating, restlessness, decreased heart rate, increased appetite, and weight gain. These symptoms begin within 24 hours of quitting and peak within a few days. Most symptoms last only a few weeks, but cravings for tobacco can continue for years. There is also a strong behavioral component to nicotine dependence. For regular smokers in particular, smoking has become so intertwined with usual daily activities that cravings and possible relapse are likely to occur when engaging in these everyday activities.

Ending Tobacco-Related Deaths

Tobacco industry responses to consumer health concerns have included the filter cigarette, reductions in machine-measured average tar and nicotine content, and, more recently, new cigarette and smokeless delivery systems. Because these innovations were perceived as safer, many smokers concerned about health issues switched to such products rather than quit tobacco use entirely. However, studies suggest these innovations provide little or no health benefit.

To end the epidemic of tobacco-related deaths, it is necessary to stop the onset of new tobacco users. However, even if no one started to use tobacco beginning today, it would take 60 to 70 years before all tobacco-related deaths ceased. Stopping tobacco use halves the risk of death from myocardial infarction (MI) within 1 to 2 years and significantly reduces the risk of cancer death within 5 years. Data also suggest that life expectancy is not significantly reduced if cessation occurs before age 35. Thus, it is important to help tobacco users quit as early in life as possible.

Product Regulation

In the United States, the nicotine, toxin, and carcinogen content of tobacco products is unregulated. The Federal Drug Administration (FDA) regulation of tobacco has been recommended by the Institute of Medicine and others. Bills to give the FDA authority to regulate tobacco have been introduced, but have not yet passed.

Stronger warning labels can increase people's understanding of the health risks of tobacco use. To be effective, warning labels need to stand out, have a visual impact, and give specific, rather than general, information. Stronger warning labels in Australia and Canada appear to have had larger effects on quitting behavior than the older labels.

Tobacco Taxes

The most effective intervention to prevent young people from starting to use tobacco and to motivate current users to quit is to increase the price of tobacco products. For every 10% increase in price, youth uptake of tobacco use decreases by 7% and adult use decreases by 4%. Equivalent taxation across tobacco products is needed, or use will just shift to other products.

Coupons and other offers reduce the impact of tax increases. There has been a dramatic increase in tobacco industry spending on these price discounts in recent years, particularly in states that have comprehensive efforts to reduce tobacco use. Other price strategies include restrictions on free tobacco product samples, restrictions on coupons or discounting, prohibiting the sale of single cigarettes, efforts to combat smuggling, and restrictions on Internet or mail-order sales.

Countermarketing Campaigns

Sustained counter-marketing campaigns are important in order to counteract the $13 billion to $15 billion spent each year by the tobacco companies to promote the use of tobacco products. Countermarketing campaigns reduce youth and adult tobacco use by changing social norms about tobacco use, increasing awareness of the health hazards of smoking and exposure to SHS, educating about tobacco industry actions, motivating people to quit, and informing tobacco users about resources available to help them quit. Media has also been shown to be effective in increasing calls to telephone cessation quit lines. Media is also used to generate support for tobacco control efforts, such as smoke-free policies.

Studies suggest that partial bans on tobacco advertising are not effective, but complete bans decrease tobacco consumption. The lack of effect of partial bans may be due to such bans being circumvented. For example, after the broadcast ban went into effect in the United States, tobacco advertising merely shifted to other media—newspapers, magazines, billboards, and the point of sale.

Efforts have been made to reduce tobacco advertising that targets children. Lawsuits against R. J. Reynolds have resulted in the discontinuance of the "Joe Camel" campaign, which targeted children, and the "Kool Mixx" campaign, which allegedly targeted urban minority youth, as well as restrictions on the marketing of candy, fruit, and alcohol flavored cigarettes.

The 1997 master settlement agreement (MSA) between the tobacco companies and the states imposed some restrictions on cigarette marketing in the United States. There could no longer be (a) brand name sponsorship of concerts, team sporting events, or events with a significant youth audience; (b) sponsorship of events in which paid participants were underage; (c) tobacco brand names in stadiums and arenas; (d) cartoon characters in tobacco advertising, packaging, and promotions; (e) payments to promote tobacco products in entertainment settings, such as movies; (f) sale of merchandise with brand name tobacco logos; and (g) transit and outdoor advertising, including billboards.

Prohibiting other retail products from having tobacco images or brands, eliminating images of tobacco use on television and in movies seen by minors, restricting advertising in magazines and other print media with high youth readership, and eliminating candy cigarettes or shredded bubble gum that is packaged to look like smokeless tobacco are other ways to reduce youth exposure to protobacco messages.

Minors' Access Restrictions

Restrictions on minors' ability to purchase tobacco are effective, but only in conjunction with other community interventions and continued enforcement. In 1992, Congress required every state to have a law prohibiting tobacco sales to minors under age 18, to enforce the law, to conduct annual statewide inspections to assess the rate of illegal sales, and to develop a strategy to reduce the illegal sales rate to 20% or less. The average violation rate decreased from 40% in 1997 to 11% in 2006.

The MSA also contained the following youth access restrictions: restricts free samples except where no underage people are present, prohibits gifts to youth in exchange for buying tobacco products, prohibits gifts through the mail without proof of age, and prohibits the sale or distribution of packs smaller than 20 cigarettes.

School-Based Prevention Programs

School-based tobacco prevention programs are effective only when combined with interventions

in the community. Quality school-based prevention programs implement tobacco-free campuses and provide curriculum that highlight the negative social consequences of tobacco use and help youth resist the pressure to use tobacco. Program effects decay without additional educational interventions, media campaigns, or supportive community interventions, and comprehensive approaches are necessary for long-term success.

Smoke-Free Policies

In 2006, the Surgeon General concluded that eliminating smoking in indoor spaces fully protects nonsmokers, but that separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposure to SHS. Although the purpose of smoke-free policies is to reduce SHS exposure, these policies also reduce cigarette consumption, increase quitting, decrease relapse, and reduce initiation. Smoke-free venues help create nonsmoking social norms and reduce smoking by adult role models. However, tobacco industry promotion of smokeless tobacco "for when you can't smoke" could negate the impact of smoke-free policies on increasing cessation.

After the implementation of smoking bans, studies have shown dramatic declines in the amount of irritants and cancer-causing chemicals in the air and improvements in respiratory symptoms and the lung function in hospitality workers. Several studies have reported decreased heart attack rates in communities after smoke-free policies have been implemented. A recent national study reported that nonsmoking adults' exposure to SHS was only 12% in counties with extensive smoke-free laws, compared with 35% in counties with limited coverage, and 46% in counties with no law.

Cessation Interventions

Brief clinician advice to quit tobacco use increases cessation rates 30% and more intensive counseling doubles the cessation rate. Cessation coaching provides practical advice about how to deal with withdrawal symptoms and the challenges of quitting and provides support to the tobacco user. Currently there are seven FDA-approved medications for treating tobacco use, and these medications double or triple success rates. Using counseling and medication together produces even better results. However, few tobacco users use these treatments. Even those that use treatment often do not use as much of the medications as recommended, which may lower success rates.

Telephone cessation quit lines increase access to treatment because they are free and generally available days, evenings, and weekends; do not require transportation or child care arrangements; and provide individually tailored help. Some quit lines also provide free nicotine replacement therapy. In 2007, all states had telephone cessation quit lines that could be reached though a single phone number, 1-800-QUIT-NOW. However, funding for state quit line services has been erratic. Even when funding is available, it is often insufficient to provide counseling and medication to all tobacco users interested in quitting.

Insurance coverage of tobacco-use treatment increases the use of effective treatments and the number of smokers who successfully quit. These treatments are cost saving, yet tobacco-use treatment is one of the least provided preventive services under both public and private insurance.

Comprehensive Approaches

Putting all the effective strategies together in a comprehensive approach has been proven to decrease the initiation of tobacco use, decrease youth and adult prevalence, and reduce disease. However, comprehensive efforts must be continued to be effective. Sustaining funding for state tobacco control programs has been a continued challenge. Most of the initial state-funded programs sustained significant cuts or were virtually eliminated. In 1998, the MSA provided $246 billion over 25 years to the states to compensate for Medicaid and Medicare costs for treating smokers. Although it was expected that states would fund comprehensive tobacco control programs with the proceeds, in 2007, only three states were funding such programs at the Centers for Disease Control and Prevention (CDC) recommended levels.

In summary, at one time lung cancer was a rare disease. Today, however, lung cancer is the leading cancer killer of both men and women. Eliminating all tobacco use could eventually prevent 80% of COPD deaths, nearly 20% of pneumonia deaths, nearly 60% of all aortic aneurysm deaths, 17% of

ischemic heart disease deaths, and more than 10% of stroke deaths. It could also eventually prevent a large percentage of cancer deaths, including more than 60% of oral cancer deaths, nearly 70% of esophageal cancer deaths, 20% of stomach cancer deaths, nearly 25% of pancreatic cancer deaths, 80% of throat cancer deaths, 12% of cervical cancer deaths, more than 25% of kidney cancer deaths, 17% of bladder cancer deaths, and 17% of the deaths from acute myeloid leukemia. The decrease in cigarette consumption has been termed one of the greatest public health achievements of the 20th century, but progress has stalled since 2002 in youth and since 2004 in adults. The challenge of the 21st century will be to resume and accelerate progress by fully implementing the interventions that have been proven to reduce tobacco use.

Corinne G. Husten

See also Acute and Chronic Diseases; Adulthood and Death; Cancer and Oncology; Cardiovascular Disease; Causes of Death, Contemporary; Life Expectancy

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Tomb of the Unknowns

Until the recent past, in every war there have been fallen soldiers' bodies whose remains could not be identified. Surely these soldiers were buried by their respective states, but the idea of erecting a monument to these unknown war dead has a relatively recent history. One of the earliest such monuments was an 1866 memorial to those unknown soldiers from the American Civil War.

Following World War I (WWI), the notion of monuments to unknown soldiers became standard for those countries that had participated in that war. In 1920, such a monument was designed when the remains of an unknown soldier from the forces of

the British Empire in WWI were interred in Westminster Abbey. Also in 1920, a memorial to the unknown dead of WWI was placed under the Arc de Triomphe in Paris by the French government.

In the United States on November 11, 1921, an unknown soldier from WWI was placed under a marble slab in the Memorial Amphitheater in Arlington National Cemetery, the last resting place of huge numbers of soldiers and several presidents in the United States. The soldier was buried with full military honors. On November 11, 1932, the completed monument, a white marble sarcophagus, was erected in the Memorial Amphitheater in Arlington National Cemetery, Washington, D.C. The stone for this monument came from Marble, Colorado. The sarcophagus is plain except that on its east panel (facing Washington, D.C.) are three carved figures from ancient Greece representing peace, victory, and valor. On the west panel facing the Memorial are the words: "Here Rests in Honored Glory An American Soldier Known But To God."

On Memorial Day, May 30, 1958, the remains of unknown soldiers from WWII and the Korean War were also placed under marble slabs next to their fallen comrade from WWI. At the time of this ceremony, the name of the monument was officially changed from "Tomb of the Unknown Soldier" to the "Tomb of the Unknowns." An unknown soldier from the Vietnam War was later added to the group. However, in 1998, through DNA testing, these remains were identified and subsequently returned to the family for burial. It has since been decided that no more remains will be buried at this simple, beautiful monument.

In the United States, the Tomb of the Unknowns stands in the center of Arlington National Cemetery, and it is one of the most visited sites in Arlington and, indeed, in the entire Washington, D.C., area. Part of the reason for this interest is related to the ceremony of the changing of the guard. The tomb is guarded continuously, that is, 24 hours per day and 365 days per year no matter what the weather, by elite members of the 3rd United States Infantry—the "Old Guard." This unit has served the United States continuously since 1784 and is the oldest active duty unit in the United States. Only certain members of this unit are chosen for the guard at the Tomb of the Unknowns. The selection process is rigorous as only well-qualified members of the army can be entrusted with the task of providing a continuous honor guard for those who represent all of America's fallen heroes.

Those members of the 3rd United States Infantry who are selected as guards wear no rank insignia on their uniforms so that they will not outrank any of the unknowns, no matter what their rank was. Each "walk" around the tomb is carried out with much ceremony. Walks last for half an hour during the summer months and 1 hour during the winter months. At night, when Arlington National Cemetery is closed, the walks are 2 hours in length. At the end of the walk, the guard is changed—a ceremony that signifies the great honor afforded this nation's war dead. Both the walks and the changing of the guard are solemn military rituals that resonate with symbolism. During the walk, the guard walks south for 21 steps (to signify a 21-gun salute), stops for 21 seconds, and then walks north the 21 steps back. This walk in front of the tomb continues for the entire shift. Naturally, the guard does not talk or acknowledge anything but the honored walk for his or her time at the tomb. The changing of the guard is a formal ceremony in which one guard is brought to the tomb to change places with the guard currently on duty. It would be the rare individual who witnesses the guarding of the tomb or the changing of the guard who was not moved almost to tears by the ceremony.

The Sentinal's Creed taken by all these members of the Old Guard is:

My dedication to this sacred duty
Is total and wholehearted—
In the responsibility bestowed upon me
Never will I falter—
And with dignity and perseverance
My standard will remain perfection.
Through the years of diligence and praise
And the discomfort of the elements
I will walk my tour in humble reverence
The best of my ability.
It is he who commands the respect I protect
His bravery that made us so proud.
Surrounded by well meaning crowds by day,
Alone in the thoughtful peace of night,

This soldier in honored Glory rest
Under my eternal vigilance.

The Tomb of the Unknowns has been guarded continuously with these solemn ceremonies since July 2, 1937. This is a tribute to the respect with which Americans honor those who have fallen in the defense of freedom.

Kathleen M. Campbell

See also Gold Star Mothers; Memorial Day; Memorials, War

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Tombs and Mausoleums

A tomb or mausoleum is defined as a repository for either the cremated ashes of a deceased person, an actual corpse, or coffin. It is the place of interment for multiple bodies built above ground level or separated from earthen material if constructed below ground level. The notions of separation from contact with the actual earth and a physical vault that can be seen, touched, or entered are essential psychological components of these placements of deceased loved ones.

While research into death and dying has developed a broad research base, the focus on tombs and mausoleums is a relatively new area of investigation. Typically the research domain of sociologists, in recent times the concept of death and its relationship to entombment and spaces of death have received an interdisciplinary focus. Investigators from disciplines such as ethnography, social psychology, city planning, and professionals from within the death industry itself have come to see the importance of these physical spaces in regard to the psychology of spatiality and memorialization of the death and dying process as a whole.

In societies that use crypts, burial chambers, or tombs as either one aspect of the postdeath visitation experience or as a final repository after the funeral rites that is never revisited, these burial spaces have several symbolic functions relating to the notion of "permanency." As death and subsequent decomposition of the body represent two of the most primal fears of humanity, the tomb plays an important role in that its functionality and physical presence play a deeper psychological role through an inter-related, three-way process reminding and reassuring those connected to the deceased, and the society at large, of several key facets related to this deep-rooted fear. This process is discussed in the following sections.

The Social-Cultural Functions of Tombs and Mausoleums

Whether housing single or multiple bodies, the tomb is a singular place that represents what has been called the *three spaces of death*. These nested or interrelated spaces are an important facet for both the deceased and the living in the crypt. There are three social-cultural functions that emerge from these spaces of death.

Reestablish the Routines of Life

Whether it is unexpected or at the end of a given time frame, death interrupts the normal ebb and flow of life. This rupture of the everyday process of living commences a process of grieving for the departed that unfolds in a series of stages, each of which are connected by an initial sense of disequilibrium and a profound sense of loss that is manifested both psychologically and physically. For many cultures, entombment in all of its various forms is seen as an integral component of stabilizing the feeling that not only is the deceased a missing physical element of everyday life, but that there is a deep, and often seemingly intangible, psychological sense of having a portion of self taken away.

In the limited research done in this area, respondents report that at the point of death of a loved one, and for some time afterward "it feels like a

part of them has been ripped away," or that "there is a part missing." The physical presence of a tomb acts as an agent of healing this sense of a physical and emotional rift and allows the immediate family and social collective to come to grips with the profound sense of finality associated with their understanding and acceptance of the concept we often term "passing away."

Just as it is recognized that language reveals the limits of a culture's understanding, so too the tomb is a form of physical language that, in the process of grieving, speaks to a community of limits and finality. In either its position above ground, its situation that all have to look up to see, or by its physical presence, the sepulcher, crypt, or mausoleum has a multilayered voice that signifies all living beings have a final point of life and that life goes on regardless of death. As such, the tomb is a point and place in binary time that acts as a physical segue between the sense of disconnectedness associated with the grieving process and the awareness that life needs to continue on.

In this role as a point of connection and unspoken physical language, the mausoleum and all its variations also function as point of control. It facilitates the gradual control over the grieving process in that the cascading processes of despair, anger, and acceptance can be experienced concretely at these sites, as they concentrate these emotions on a thing that can be seen. Related to this point, they also act as a point of control. One of the critical fears of the human condition is death and its seemingly capricious nature. Thus, the tomb by its very nature and function acts as a point of control in a process and understanding that is seemingly uncontrollable.

Memorialize a Life Lived

While a tomb has a key place in orchestrating control over the final facets of the grieving process by providing a sense of location, another psychological role is that it also imparts a sense of time and permanence by its spatiality. Thus, it becomes a place of memorialization.

The structure itself affords opportunities for two key courses of action in this regard. First, it provides a place of finality or closure in regard to the interconnected elements of the actual death if it was unexpected, the death bed if death takes time, the emotional components of the surrounding loved ones, the ritualized facets of the funeral, the postfuneral social or ritualized events, and the laying to rest of the departed. It is recognized that all societies and cultural groups strive to control death in some way. The tomb reconstructs a sense of hope that life with all its hardships has come to an end, and the one who has died is now at peace or, in a sense, simply asleep. Thus, in many parts of the world, tombs and tombstones are consistently inscribed with this form of language, such as "Rest in Peace," "Laid to Rest," and "Fallen Asleep." Thus, a sense of hope is overlaid onto one of humankind's fundamental fears, the fear that there is nothing after death, or what is commonly called existential angst.

The second aspect of memorialization ritual activity and frameworks of understanding tombs brings into play that not only do they bear the name or signify the place of interment of an individual but they also instigate revisitation. While tombs can be revisited with all of the rituals that are attached to this process, such as the giving and refreshing of flowers in the Western world, tombs can also be revisited as memory. Thus, the family and perhaps society as a whole can have an ongoing relationship with the dead, even through the process of simply idealizing where the dead have been laid to rest. Therefore, the tomb can play an important part as memorialization gives stability to the human condition in that not only do we as a species cling to life at all costs but, in regard to our dead, we have a tendency to want to see them as part of the ongoing living as well. Also, the spatial psychology of the tomb acts as the means by which we can concretize life after death as well. That is, by being able to see a definitive, stable structure, we can not only cope with death in life, but also hope that the same stability exists after death. Thus, in addition to the religious elements that often accompany a tomb, this sense of physicality gives another sense of sacred control. We compress our paucity of understanding the concept of the infinite and the universe into a smaller space, a space where the concepts of death can be dealt with and accepted.

Stabilize Death in the World of the Living

A key facet of death is that it tends to induce a sense of disequilibrium in those closest to the deceased. The human condition is reliant on both

a psychological and actual sense of horizon and of symmetry in order to make sense of the immediate world around them and the universe at large. The tomb or mausoleum provides this stabilizing sense in that it gives dimensions, a plane of horizon and a definitive volume, to a landscape. This stabilization also serves to further add to the memorialization process in that it gives an evaluation of life. In its firmness, this final resting place nonverbally says, here was a life lived and a life remembered. The landscape, symmetry, texture, and dimensions of the tomb give stability within the human concept of the possibility of "nothingness" after death, and the symmetry and horizons it creates give a sense of constancy when death tends to be framed as the unknown.

Another key aspect of the tomb is that it provides tangible evidence, or an impression, that the body is separated from contact with the earth. This sense of solid distance provides psychological comfort to another of humankinds' greatest fears, which is the decomposition of the body after death. While this respect is given to the dead, it is also a part of the well-being of the living. The tomb offers hope that when the living die, they too will be interred in a similar fashion, and while decomposition will occur, the remains will not become an actual part of the ground and, therefore, there will be a semblance of ongoing life.

The tomb is an important aspect of not only death, but also of life in general. It is in many ways a segue between living and dying. In a world that is becoming increasingly characterized by what has been termed *memento mori*, where concepts of death and dying have been removed from everyday existence and become a hidden industry in the industrial first world, the tomb is a constant reminder that not only is death inevitable, but that psychological stability is also grounded in our ability to see death and accept it. While the tomb can be seen as shelter for the dead, it is more importantly a psychological shelter for the living.

Phil Fitzsimmons

See also Cemeteries; Columbarium; Decomposition; Monuments; Tomb of the Unknowns

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Tombstones

A tombstone is a marker for a grave. Historically many graves have gone unmarked, but where tombstones are used, across cultures these markers are made of different materials. There are graves marked by fieldstone that are either placed upright or horizontally on the surface of the earth. Fieldstone can be any type of rock, but it is generally made of local material, such as sandstone. Usually nothing is inscribed on the stone, which serves solely to inform the living that someone is buried below. One example is historic African American slave cemeteries located in the southern portion of the United States that are replete with irregularly shaped fieldstones.

More elaborate tombstones are made of materials such as granite, marble, slate, limestone, iron, and bronze and are often carved with descriptive notations, inscriptions, and are sometimes ornately decorated. Tombstone grave markers are also perishable. Wooden crosses weather and deteriorate over time. Some wooden crosses are plainly carved, while other crosses are carved into hearts or even stylized people. This essay offers a brief history of tombstones and provides a discussion of the functions, uses, and culture of tombstones.

History of Tombstones

Prehistoric groups throughout time marked their graves with a stone or a horizontally placed slab of stone. Neanderthals may have been the first species to mark their graves. At the rock shelter site located at La Ferrassie in France, which dates to 70,000 years ago, paleoanthropologists have found eight buried Neanderthal skeletons. One of these individuals was buried under a triangular stone, thus representing what some analysts believe to be one of the earliest tombstones.

Ancient Egyptians, Greeks, Romans, and Persians at times marked an individual's grave with a stone. In Greek society, for example, the only individuals awarded a tombstone were those Spartan warriors who died in battle and mothers who died in childbirth. But generally tombstones were not considered essential until 1804, when on June 12 of that year, France created the Decree of Prairial, Year XII. This decree established that burials were not to be in churchyards and towns but in cemeteries outside the city, and that common graves would be replaced by juxtaposed graves. Individuals could buy a grave plot for perpetuity. The Decree of Prairial also stated that a tombstone or other burial mark could be placed over the burial site of a loved one. In one cemetery, called Père-Lachaise, 114 tombstones were placed in 1804 and over the period of 1814 through 1830, an average of 1,879 tombstones were placed each year. This decree propelled people to claim a grant of land, big or small, and designate that plot as theirs by a tombstone or monument. To the present time, the tombstone has been integral to a gravesite.

The Social Science and Historical Use of Tombstones

Scholars use historic and modern cemeteries as laboratories for collecting and analyzing data. With a tombstone library of millions, anthropologists and historians, for example, investigate cultural, linguistic, biological, and archaeological data. Each tombstone provides insight into a person's life as marked in stone. Information extracted from tombstones can be used to address broad questions involving biological, economic, social, technological, and religious issues. A single tombstone display may offer numerical, linguistic, biological, epidemiological, geological, iconographic, and epigraphic information.

Sociocultural Characteristics

Rich cultural information can be derived from tombstones. The size of the marker and the material used to create it is indicative of the wealth and status of the individual. A tombstone epitaph may also communicate information about one's low status in life. One such example is found on a tombstone located in Alabama that reads, "E. L. A. Wife of . . . and . . ." (1843–1918) "was pleasant to live with." While the deceased's two husbands are named on her gravestone, the wife is identified by three initials.

Even the method used to engrave the deceased's identification, birth and death dates, and epitaph are suggestive of a person's station in life. The wealth of the deceased can be suggested by the size of and material used to create ornate and elaborate tombstones. The use of a sharp object or a stick to scratch into a hardening cement tombstone versus a stone carved by a stonemason not only speaks to the wealth of the buried but, in the case of the hardening cement, those sentiments and descriptions made by scratches are quick unedited thoughts. Inscriptions carved by a stonemason can be edited and corrected for spelling. Carvers or stonecutters of tombstones also imprint their mark on the front or on the back of the tombstone.

Military veterans are often buried together in a section of a cemetery with each headstone appearing in uniform fashion. But on many of the older tombstones, a written legacy is offered in the form of epitaphs, photo portraits, and engravings. Symbols or a more direct indication of one's occupation also have been listed, thereby providing an indication of one's occupation. Examples include the display of a sheriff's star or a medical caduceus. Other examples are engravings of a semitruck, a trowel, and even an embedded screwdriver in the tombstone, again suggestive of one's occupation.

Language inscriptions and photo portraits as well the documented location of the individuals' city and country of birth are useful for establishing one's ethnicity. Heraldic crests point to a country of origin or ancestry, thereby providing information that is useful to trace migration patterns. Tombstones of Japanese individuals often have

family crests called *mon*. The mon of the Motoyama family is a goose, while the Murata family is indicated by a mulberry leaf.

Symbols of Affiliation

Religious symbols allude to an individual's religious affiliation. Examples of Christian symbolism include carvings of Adam and Eve, a cross (Greek, Latin, Celtic), the chalice, wafer and grapes of the Eucharist, the dove from heaven representing the Holy Ghost, angels, and nails and the crown of thorns representing the Crucifixion. Tombstones with the star of David, the menorah, a Levite pitcher, a yahrzeit candle, or the indication of years according to the Hebrew calendar represent the markers of Jewish individuals.

Over 1,200 symbols and acronyms are recorded on tombstones in the United States alone, representing organizations, clubs, and societies, past and present, to which deceased individuals were members. Examples of these symbols refer to the Masons, Shriners, Boy Scouts, and Woodmen of the World. Familiar acronyms include CSA (Confederate States of America), GVS (Giuseppe Verdi Society), ORC (Order of Railroad Conductors), and NEFMC (New England Fat Men's Club).

Tombstones of males, females, adults, and children often vary in size, shape, and stone material. The male tombstone may be more ornate, larger, or made of marble, while the female tombstone is simple, small, and made of sandstone or granite. An infant's or child's tombstone may be small with carvings, such as a lamb indicating innocence. In the past, the tombstone of an unbaptized infant was often without an inscribed name.

Cause of Death

Demographic information, such as the number, sex, and age, of the deceased are easily obtained from tombstones. If needed, an average age at death can be determined for each decade the cemetery was in use. The same is true for infant and childhood mortality. Such statistics can be used to assist in determining the health of a population or serve to understand the effect of an epidemic, war, or natural catastrophic events.

Older tombstones display epitaphs that indicate the cause of death, such as cholera, yellow fever, flu, drowning, murder, childbirth, explosion, or battle. Multiple tombstones from a family with dates of death on the same day or close together might suggest that death may have resulted from a fire, accident, or an epidemic.

Seriation

A relative dating process called seriation is useful to access the popularity of a style of artifact over time. One examination of the application of seriation involves the change in popularity of designs on New England tombstones. Iconographic representations on tombstones spanning the years of 1720 to 1830 at a cemetery in Stoneham, Massachusetts, were tabulated, the results of which portrayed a pattern involving the use of three popular designs. Each design followed what is known as a battleship curve. First, a design was popular, then became very popular, and then waned in popularity as another design gained in notoriety. From 1700 until about 1760, the death's head design found at the top of the tombstone increased in popularity until its peak in the 1730s through the 1750s, and then decreased in popularity when a new cherub design started to replace the grisly death's head. The cherub is found to be at its greatest popularity in the 1780s, and then it lost favor to a design depicting an urn and willow. The urn and willow increased in popularity throughout the early 1800s.

Humorous Tombstone Epitaphs

Numerous compilations have been made of epitaphs on tombstones. Some epitaphs are humorous as noted in the following:

> Here lies the bones of a man named Zeke,
> Second-fastest draw in Cripple Creek.
> (Boothill; Cripple Creek, Colorado)

Other epitaphs are more poignant:

> My wife from me departed
> And robbed me like a knave;
> Which caused me brokenhearted
> To sink into my grave.
> My children took an active part,

To doom me did contrive;
Which stuck a dagger in my heart
That I could not survive.
(Vermont epitaph)

Or:

His brains were lead; and with the dead he lies;
He said but little, and that little dies.
(Epitaph of a hospital patient; 1662, England)

Historical Preservation Efforts

Tombstones represent an important cultural artifact and record of the past and for this reason organizations such as the Association for Gravestone Studies seek to preserve and record information from grave markers throughout the United States. As other methods of body disposal gain popularity, such as cremation, these efforts are increasingly important. Although such organizations focus on the tombstones of the past, contemporary cemetery regulations dictate tombstones be flat and low to the ground, primarily to facilitate the perpetual maintenance of a cemetery. Thus, uniformity and practical maintenance issues take precedence over the artistic and verbose tombstones of earlier times. The result is a silencing of a final expression of the self through epitaph voice of the individual buried below the tombstone.

Keith Jacobi

See also Cemeteries; Christian Beliefs and Traditions; Memorials; Memorials, Roadside; Symbols of Death and *Memento Mori*

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Totemism

The word *totem* comes from the Ojibwa, an Algonkin language from the Great Lakes region of North America. It first appeared in ethnographical literature in 1791 in the memoirs of a fur merchant, John Long, but it remained unnoticed until John MacLennan used it as an analytical category in two papers he published in 1869 and 1870. MacLennan defined totemism as the practice, reported not only in North America but also in Australia, of naming clans and exogamous groups according to an animal or a vegetal species. He showed that this practice was accompanied by the belief in a special, intimate relationship between the members of each clan and their totem, sometimes reinforced by the idea they all descend from it. Members of each clan are thus said to treat their totem with the respect due to an ancestor: they must not kill it if it is an animal, cut it or gather it if it is a plant, and they must not eat it. Animal totems are preponderant among North American tribes. For instance, the main clans of the Ojibwa at the beginning of 20th century were named marten, loon, eagle, salmon, bear, sturgeon, bobcat, lynx, crane, and chicken. Australian totems, however, often include plant names, and also meteorological phenomena (such as wind, hail, or lightening), artifacts (such as anchor, boomerang, or pirogue), and even sometimes terms related to the human body (such as boy, bosom, clitoris, or corpse).

It might seem irrelevant in at least two ways to devote an entry to totemism in this *Encyclopedia of Death and the Human Experience*. Death has been indeed thoroughly absent from the passionate debate on the nature and origin of totemism that has agitated not only anthropology but also philosophy and psychoanalysis from the end of the

19th century to the middle of the 20th century. Moreover, since Claude Lévi-Strauss convincingly revoked totemism as an "illusion" in his famous essay written in 1962, this idea has tended to disappear from the social sciences. However, totemism has been recently revived in anthropological analysis by Philippe Descola, and it seems that death, as a human experience, could hold a significant role in the new understanding of this problematic concept.

The Golden Age of Totemism: Australian Hopes and Disillusions

The two articles by MacLennan initiated a heated debate through which the greatest names in anthropology, among which James George Frazer, Bronislaw Malinowski, Émile Durkheim, and Franz Boas laid the early foundations of the discipline. But the interest in totemism reached out from the limits of anthropology to the whole humanities. The debate involved not only philosophers but also psychoanalysts after Sigmund Freud's celebrated essay *Totem and Taboo* in 1913. All these authors believed that totemism could give insight into the most "primitive" forms of religion, and they rivaled in reconstituting from what could be observed at their time a hypothetical "original" state of human thought, in which culture would hardly be separated from nature.

In 1887, it was James George Frazer who gave the first synthetic account of the available anthropological knowledge on totemism in a small book simply called *Totemism*. He updated this work in 1910, publishing four volumes of the most monumental compilation of data on this topic. By the beginning of 20th century, the focus of the debate had shifted from North America to Australia, thanks to the extensive description by Walter Baldwin Spencer, Francis James Gillen, and Alfred William Howitt of several Aboriginal societies, such as the Aranda of the central desert. Their description of "still active" and more "primitive" totemic systems aroused the hope they would complete the American data, which were sometimes patchy and believed to represent a more "evolved" state of totemic religion. Australian facts, nevertheless, brought more problems than solutions, and while Frazer and Durkheim kept praising the data provided by Australian ethnography as the "purest" form of totemism ever described, they strove to make it fit in a single model together with the knowledge already available.

As was already known through North American facts, it is not only clans and other exogamous groups that can be named according to natural species, but also the sexes—a different animal or plant being attached to men and women of the group—and individuals. Among the Kamilaroi of the Australian east coast, for example, sorcerers are associated with animals and most of all to reptiles: They are believed to host them in their body and sometimes produce a tamed animal to prove their power. But more challenging for the theories of these authors, Australian ethnography showed a great variability in the link between the attribution of totems and the exogamic rule. Indeed, among several of the Aboriginal societies, such as the Aranda described by Spencer and Gillen, totems were not inherited, but attributed to a child according to the place, itself, associated with a particular animal ancestor, where the mother felt the first signs of her pregnancy. Even more surprising, the two ethnographers reported that the interdiction on the killing and the consumption of the totem animal was not an absolute one among the central tribes of Australia. Therefore, rather than reinforcing totemism as a category, Australian ethnography was undermining its two supporting pillars: exogamy and taboo.

Several anthropologists tried to overcome these difficulties by producing theories of origins that would make these heterogeneous facts fit into a single evolutionary scenario. Frazer, notably, explained the loose link between exogamy and totem and the moderate taboo on killing it among the Aranda by a hypothetical original state of totemism, characterized by endogamy and ritual consumption of the totem species.

Claude Lévi-Strauss and the "Totemic Illusion"

In the short pamphlet against totemism he published in 1962, Lévi-Strauss noted that studies on totemism had tended to conflate two different phenomena: first, a general process of identification between particular social groups or individuals and an animal species or a variety of plant; second, a principle of social organization consisting in distinguishing kinship groups with names of natural

species, which is but one among many techniques of group naming. Yet, while these phenomena exist independently in many places, cases where they organically coexist in a single society are more seldom, and it is sometimes doubtful that institutions described as "totemic" really concern both these aspects. Even the Ojibwa case, from which the term originally came, is uncertain, as ethnographers later suggested that in his use of the term totem, John Long confused the practice of clan naming with the belief in animal guardian spirits that were called by something completely different. Could totemism be nothing but a mere misunderstanding?

Lévi-Strauss goes further into denouncing what he calls a "totemic illusion." In his view, totemism is an illusion because it particularizes as a distinct and "primitive" institution what is in fact one of the multiple manifestations of a universal intellectual faculty of world ordering. Lévi-Strauss shows through a convincing demonstration that what has been called totemism is a classificatory device that uses contrasts in the natural world to think and organize significant differences within society. In other words, what matters is not so much the similarity postulated between the group *a* and the species *x,* but the correlated differences between a series of contrasted natural species (*x, y, z*) and a series of contrasted social groups (*a, b, c*). What so-called totemic systems postulate is that there is as much difference between the group *a* and group *b* as between the species *x* and the species *y;* between the group *b* and the group *c* as between the species *y* and *z*; and so forth. Under structuralist analysis, totemism thus evaporates, revealing itself as a mere instance of the universal ability of the human mind to think about the world through contrastive oppositions.

Totemism Resuscitated: Descola and the Ontological Way

Revoking totemism on the basis of its "social organization" dimension, specifically the naming of distinct groups, leaves unresolved the problem of the identification of groups and individuals with animal or vegetal species. Philippe Descola recently proposed to reconsider the problem in an "ontological" perspective. Totemism, as an ontology, is characterized by the idea that humans and nonhumans share what he calls "aggregates of similarities." He grounds this reappraisal of the notion on a comparative account of the terms by which Australian societies describe their own totems. He shows that this totemic terminology describes a series of physical and moral qualities shared by the members of a group and their totem. Thus, among the Australian Kariera, the sections "fast" and "warm-blooded," and the sections "slow" and "cold-blooded" are each associated to a species of kangaroo, one moving quicker than the other; the sections "fast" and "warm-blooded" and "slow" and "cold-blooded" are each associated to a species of goanna, one being more "massive" (and supposedly slower) than the other.

This enables Descola to study in a single perspective many different practices of physical and moral identification between humans and nonhumans. Ethnographers, for instance, have given evocative descriptions of the different hair arrangements by which the Plain Indians of the clans of the Crow, of the Buffalo, and others imitate their totem. To avoid the dissolution of the concept into too vast a category, Descola defines totemism as an ontology that postulates a continuity between humans and nonhumans, both on the plane of physicality (which designate not only the aspect of a given being, but also its characteristic behavior) and on the plane of interiority (mostly the attribution of moral qualities). Totemism thus supposes a close relationship between humans and nonhumans, inasmuch as a human's life can be equated to a plant's or to an animal's life: "The life of a bat is a man's life" is a saying by the Wotjobaluk of Australia, where the bat was the totem for the male class. Furthermore, in many societies, injuring a totem animal was believed to have a direct effect on the very body of the members of the associated group. Also in many cases, the killing of a totem animal was avenged by the members of a clan, and it could be punished by death.

Experiencing Nonhuman Death as a Human One

One of the best illustrations of the quasi-equivalence postulated between the life of the totem and a human life may be that when a totem animal or plant is involuntarily killed or found dead, it is cared for and buried as a clansman. Frazer reported that among the Samoan, when a man of the Owl totem found a dead owl, he would weep over it,

beat his forehead with stones, and then wrap up the bird and bury it as if it had been a human being. Surprisingly, although similar facts have been reported by several authors, death has remained, until now, peripheral to the debate. Yet, following this new understanding of the notion, totemism could eventually be characterized as an ontology in which the death of a natural species, animal or plant, is avenged like a human death, ritually treated like a human death, and thus somehow experienced like the death of one of our own kind.

Grégory Delaplace

See also American Indian Beliefs and Traditions; Animism; Australian Aboriginal Beliefs and Traditions; Death, Anthropological Perspectives; Freudian Theory

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Transcending Death

One remarkable paradox of existence is that the obvious decay of human bodies after death has frequently been countered by beliefs in immortality. Myths, religious doctrines, and philosophical ideas explaining this possibility reveal the power of meaning making as an integrated process of human thought and feeling. Such afterlife destinies are often shaped by basic ideas of reciprocity fundamental to ordinary social organization but now elaborated into doctrines of merit associated with divine judgment or processes of karma. Rituals regularly frame these ideas and help manage human emotions surrounding them, especially that of hope.

Meaning Making and Survival

Death transcending beliefs, originating in this characteristic drive for meaning, have survival as their goal and express a wish for a better life, unconstrained by the limitation of death. Religiously, they reveal a longing for some paradise or heaven in which evil is overcome and a union with the divine is achieved. The key emotional basis for pursuing such transcendence is that of hope, with acceptance of the beliefs that make it possible lying in the nature of faith and in belief in an ultimate embodied state or in a deity transcendent over all things.

Hope

Hope is as integral to death transcendence as to survival in life itself. It affirms the worthwhileness of existence and looks to future goals that may not be apparent in the present. Hope generates the ongoing success of community life and, in the context of death, depends on being widely shared by a group that is able to sustain individual members who may have, temporarily, lost hope and are in despair. Hope infuses the human imagination when it constructs myths, and religious, philosophical, and political theories about existence and the nature of death. While such a picture of the meaning of life can assume an order of reality that denies the validity of the schemes of other groups, its success depends upon the affinity individuals feel toward them, and this may change over time. As emotional beings, we are encouraged to pattern our feelings in particular ways and to share expressions of our moods. This management of human emotion is a fundamental task of society and has traditionally been undertaken by what we call religion, especially as far as death is concerned. An allied issue is that of morality, the sense of values a society prizes and applauds in its members. This moral aspect is of profound importance for death transcendence because hope is not simply an optimistic energy but is grounded in this moral domain

of commended values, ensuring that hope is given some degree of substance by making it integral to the relationships that constitute human communities. It is this moral value, born of daily reciprocal relationships, that drives religious ideas of death transcendence and the ongoing worth of human existence despite the constraints of death.

Reciprocity, Merit, and Identity

At the foundation of much human life are ideas of reciprocity, of mutual giving and taking and giving again, that build up a society. In traditional sociological terms, such a society is a moral community, and it is the reciprocity that makes a moral community that also serves as the basis for transcending that community and for transcending death itself, the ultimate constraint upon community values.

The world's religious traditions operate on such schemes of reciprocity, extending them to embrace an afterlife on the belief that what is done on earth will have consequences for the afterlife. Death transcendence is rooted in the human liking for reciprocity and its outcomes. Death exists because of some wickedness or act of disobedience toward divinities, supernatural agents, or some principle of the universe. In Judaism and Christianity there are myths of the "fall" of humanity by which disobedience to divine commands brought death in the first place. This is also evident in Islam. These traditions developed ideas of punishment or purgation in the afterlife as part of a process of finally transcending death. The distinction between hell and heaven, along with the intermediate possibility of purgatory, offers one broad scheme of death transcendence.

In the Indian traditions of Hinduism, Buddhism, and Sikhism, human actions are deemed to have either a positive or negative moral nature in a system of karma that determines one's destiny after this life. Karma is one example of the idea of merit, that "commodity" that is reckoned to belong to people who have behaved well, obeyed commands, or otherwise won the commendation of their society or of the deity of that society.

Merit is a moral means of transcending evil or bad behavior. Just as merit brings praise from society to some of its members in this life so, too, is it reckoned to have an influence over life after death. Merit becomes the basis for salvation in heaven or for a good reincarnation in another life. Merit is integral to much death transcendence. In Christianity, merit plays a major part in theological developments concerning death and is focused in the person of Jesus Christ. He is reckoned to be the one who has, through his morally perfect life and self-sacrifice, gained sufficient merit to ensure the salvation of the whole of humanity and to guarantee them a heavenly afterlife. His resurrection is the quintessential symbol of death transcendence in Christianity.

One of the key debates in the religious Reformation that reshaped European civilization in the 16th century by creating Protestantism focused on who had control of religious merit and whether individuals could earn it for themselves through pious lives and actions. The medieval Catholic practice of paying for masses to be said for the dead to assist their passage through purgatory and on into heaven was seen by Protestants as a gross error. For them, death transcendence was achieved by and through Christ, and by faith in him, and not by reliance on human activity, even if that activity took a religious form.

In the different world of traditional societies with strong ancestor beliefs, merit still operates as the ancestors bless good behavior and curse bad behavior; They may cause the living to flourish or to suffer. Such ancestors have, in one sense, transcended death and now act from the other side of mortality. Because of this, it pays to treat them well and to observe social moral codes.

Ritual Transcendence

Rituals are important in many of these contexts as with rites of passage creating ancestors of the dead, facilitating their transmigration, or ensuring that the dead progress into heaven or paradise. Rituals do this while providing patterns of shared behavior in which ideas and emotions interact with each other and sustain participants. Funerary rites often provide one such context in which the fact of death and emotional reactions to death are given an arena in which to operate. In such contexts, grief, as the response to bereavement, can be both expressed and managed, and individuals and families can be supported by their wider kin and community. Rituals also take time and may involve a series of activities that relate to the changing state of bereaved people. The period of death itself is followed by treating the

corpse through burial or cremation and this may be followed later by the construction of grave markers, by rites performed with cremated remains, or with anniversary visits to funeral or memorial sites. Such a passage of time allows bereaved people to appropriate their newfound emotions of grief and, with time, to look to their future activities. Rituals foster hope rather than despair and in this sense contribute to death transcendence.

Knowledge Transcendence

In general terms, to discover the meaning of life events is, to some degree, to transcend them. To know why something has happened is, already, to begin to come to terms with it and not be "overcome by events." And this feature of discovering why something has happened has frequently been the case with death, as many societies generate patterns of ideas that provide a rationale for ascribing some positive function to death and for managing sets of emotions related to it. Many would identify religion as that sphere of human endeavor that manages these emotions in ways that foster the well-being of society at large. The Eastern religious traditions of Hinduism, Buddhism, and Sikhism developed ideas of a transmigrating spirit that left the body at death in order to enter new forms of future being. Middle Eastern and Western forms of Judaism, Christianity, and Islam took a different route that promised some kind of transformation of the body ready for life in heaven or in some transformation of the earth into a garden paradise.

Behavioral Transcendence

It is seldom enough for human beings to only; think about the great themes of life and death, much more is achieved when they are embodied and enacted. Here, both ethical living and ritual practice have their part in this process of embodiment, of actively participating in the stories and beliefs that give meaning to our lives. This is where funerary rites come into their own as a means of engaging with the truths by which we live. To dig a hole and bury someone in it or to light a funeral pyre and have a corpse consumed by it, is to engage with death in a pragmatic fashion, it is to face the challenge and not to experience defeat. This has been a major adaptive capacity of human beings, not simply to engage with ideas of death in some abstract fashion, but to engage their allied emotions in and through ritual performance. This is not to say that any ritual guarantees the welfare of each individual participating in it, nor that grief is easily controlled, or that the hurts of life are all healed, but it does mean that this occurs frequently enough to have ensured the longevity of group ritual activity. In this sense, rituals may become vehicles of transcendence of death.

Symbols of Transcendence

As self-conscious beings, the idea of death as simple inertness does not seem to correlate with the ordinary sense of being alive. We find it hard to think of ourselves as dead. The analogy of sleep only partly matches the case. There is an empathy in individuals when relating to others that is able to imagine that they feel and think as we do ourselves, and because it is hard to think of ourselves as not existing, it becomes equally difficult to think of others as ceasing to exist, even when they die. This is where a whole series of beliefs emerge to offer symbols of transcendence, central to which are those of the soul and of resurrection.

The Soul

The idea of an immortal soul is a prime expression of transcendence. At the popular level, it sets a difference between the body that rots and some other real source of life that continues after death. This idea of soul as some kind of energy that brings a life force to the body is one of the most successful of all human ideas. Whether in innumerable traditional communities and the world religions or in the classical philosophies of Greece and Rome, some notion of soul or spirit has emerged as a viable explanation of why people may be alive at one moment and dead the next. It has also explained how life comes to babies in the womb. Soul theory is the prime theory of death transcendence. In the 19th century, much was made of it by the anthropologist E. B. Tylor when he devised the notion of animism to describe beliefs in energy entities underlying the life of humans and also of some other aspects of the world. Interestingly, Tylor had wanted to call his idea "spiritualism," but that had, by then, come to be the name for a

kind of religious movement that used mediums to contact the dead. Indeed, Spiritualist Churches now exist in most countries and complement the age-old customs of many cultures that often possessed means of communicating with the dead, itself a form of death transcendence. Just how the soul would survive and what quality of existence it might have in another world is the theme of the merit it may be said to have accumulated. What is true is that behavior in this world is always linked to the status of the soul in the next.

Resurrection

An even greater connection between this life and a life after death is evident in the idea of resurrection. This notion emerged, for example, in Judaism a couple of centuries before the time of Jesus as a way of arguing that martyrs and similar heroes of faith should not die in vain, but have their meritorious lives and acts vindicated. God would raise them from the dead. This general idea of death transcendence shows with great clarity the importance of moral worth to death and afterlife. These ideas focused on the case of Jesus and in the emergent Christian belief that his perfectly moral life and self-sacrifice was vindicated when God raised him from the dead. Christianity then argued that those who believed in Christ would also, in due course, be resurrected. This belief took shape in groups of people who stressed the nature of hope and of trust focused in Jesus, but which they shared among themselves. Indeed, these early church communities even described themselves as being the body of Christ. It was as though their very existence, in life, enshrined the experience of death transcendence. This was reinforced by a variety of experiences and rituals that reflected death transcendence. Baptism, for example, symbolized a death to an old way of life and a rebirth into a new and spiritual form of existence. The waters of baptism were as much a watery grave as they were the waters of rebirth, of a spiritual womb. The Eucharistic meal of bread and wine also spoke of providing a spiritual food that enhance this life in the spirit and would sustain believers into eternal life. This is a good example of how daily phenomena such as a meal could be symbolically utilized to express a transcendence of ordinary life and of death itself. Over time, the Eucharist provided the basic material for use in the ritual of the "last rites," often called in Latin the "viaticum," itself meaning food for a journey. The church prepared the dying person to transcend death. Here the symbolism of baptism, of the Eucharistic meal, and of the Resurrection of Christ combined in a ritual of hope for the future.

Rapture

One of the earliest Christian beliefs was that the resurrected Christ would soon return to earth and gather the faithful around him. Living Christians would rise into the air to meet the coming Christ. But early believers soon found that some of their number actually died before this event took place. This led Paul to write and explain that the dead would not lose out at this great day. Indeed, they would be resurrected and be among the first to come with Christ and then meet the living Christians as they, too, rose in the air. Such dramatic visions of death transcendence gained incredible popularity among some late-20th-century Protestants in the idea of "the rapture." This was presented in story and film forms in a multimillion-dollar level of popular interest in what became known as the "left-behind" motif. With the faithful risen to join Christ, unbelievers would be left behind to suffer all sorts of calamities and evils at the hands of the devil and his hosts prior to the final destruction of the devil and all evil by Christ and his armies. This scenario offers a highly triumphant form of transcendence that deals with death alongside all other evil in one strategic movement.

Enlightenment, Release, and Harmony

Traditions emerging from India have, in addition to adopting transmigration as a partial form of death transcendence, sought mental states that transcend the disquiet of human life in forms of enlightenment that embrace the fact of death. The idea of *moksha,* or release, of freedom from *samsara,* or cycles of rebirth, and of enlightenment itself, nirvana, are all grounded in some sense of transcendence. Other traditions from China and Japan, in Taoism, Shinto, and Confucianism, though each possesses many variant perspectives, tend to approach transcendence in terms of a proper participation in the nature of things as they

are, including the fact of death, often with a commitment to the role of family and ancestors as a wider frame in which human beings come to a sense of fulfilled identity. Transcendence involves an insightful maturing of the moral self in society and in the natural order of life and death.

In every context, the human drive for meaning identifies evils and advocates means of overcoming them. The imaginative dynamics of myths and rituals engage human ideas of merit to foster hope and the possibility of survival against all apparent constraints.

Douglas J. Davies

See also Eschatology; Heaven; Hell; Immortality; Reincarnation; Resurrection

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VALHALLA

Valhalla is the conventional English-language rendering of Old Icelandic *Valhöll* (The Hall of the Slain), which, according to Nordic mythology of the Viking Age, is a paradise reserved for warriors who died in battle, presided over by Odin, the god of war. There they feast every night, while by day they fight to the death, reviving at nightfall to feast together once more. These pleasures will continue until the end of the world, when they will join the final battle, fighting alongside the gods against giants and monsters. The evil forces will be destroyed, but so will the earth itself, most of the gods, and presumably the warriors from Valhalla. This cosmic catastrophe is *Ragnarök,* "The Doom of the Gods."

The concept of Valhalla was essentially aristocratic and probably meant little to people of other classes. The basic image comes from the real-life situation of a war band gathered around the leader to whom they have given allegiance, living in his hall and feasting at his expense, and eventually risking their lives in his service. The earliest mentions of Valhalla are in poems honoring the deaths of two kings in battle—Eirík Blood-Axe, a Norwegian who ruled the Viking Kingdom of York (d. 954), and Hákon the Good of Norway (d. 961). They were composed by Icelanders in the service of these kings and are authentic heathen texts, for Iceland and Norway did not accept Christianity until the end of the 10th century.

The first poem, *Eiríksmál,* describes Odin telling the dead *einherjar,* "chosen champions," in Valhalla to prepare to welcome Eirík; they should spread rugs on the benches and bring drinking horns, and the valkyries must proffer wine. When one of the other gods asks why such a fine king was not granted victory, Odin replies that "the grey Wolf gazes upon the homes of the gods"—implying that Ragnarök is drawing near, and Eirík will be needed there.

Hákonarmál opens with a battle scene; at first King Hákon is winning, but then he is summoned by a valkyrie, who tells him it is time for him and his men to go to "the green world of the gods" to join Odin's forces. The gods welcome King Hákon into Valhalla and assure him that although Odin decreed his death, this does not mean that the god has any ill will toward him.

More details about Valhalla itself can be found in *Grímnismál* and *Hávamál,* poems that cannot be precisely dated but are entirely related to topics from heathen mythology. Valhalla is a huge building, gleaming with gold, with 540 doors, and at Ragnarök 800 warriors will go out from each door to face the Wolf (stanza 23 from *Grímnismál*). Other early sources say it is roofed with shields or thatched with spears, and that armor and weapons are piled on its benches.

Over two centuries later, when Iceland had long been Christian, the scholar Snorri Sturluson (1178–1241) wrote a treatise on myths (the *Prose Edda,* ca. 1220) in order to explain the heathen allusions in Iceland's older poetry. Quoting various references to Valhalla, he described its size, the unending supplies of boar meat and mead produced by a supernatural goat, and the pleasure its warriors took in perpetual

fighting and feasting. He also regarded it as the place where the gods assemble, led by Odin.

Snorri also wrote a history of the kings of Norway (*Heimskringla*), in which the first section (*Ynglingasaga*) presents various mythical figures that were human beings whose power and prestige caused their followers to think they were gods. Yet even this rationalized interpretation includes a mention of Valhalla. Snorri says that Odin, who was a wise ruler, made it a law that dead men must be burned, and their possessions laid with the corpse on the pyre—"thus every one will enter Valhalla with whatever riches he had with him on the pyre."

An important feature of Valhalla, both in Snorri's work and in the old poems, is the presence of valkyries, supernatural female beings whose name means "Choosers of the Slain." In *Eiríksmál,* Odin bids them to prepare to welcome Eirík, while *Grímnismál* (stanza 36) lists 13 of them who serve drink at the everlasting feast. The scene in *Hákonarmál* where an armed valkyrie appears on the battlefield to lead the king to the world of the dead expresses what was probably the original concept—fierce war goddesses whose primary task is to decide which warrior shall die. Their individual names reflect their war-like functions, not their role at the Valhalla banquet, for most are combined out of words meaning spear, battle, victory, mail coat, and the like. An alternative name for the whole group is *skjöldmeyjar* (shield-maidens). However, there is evidence from other poems that valkyries also acted as guardian spirits to living warriors, bringing them luck and protection in battle and becoming their lovers.

Archaeological evidence confirms the descriptions from the surviving texts. The island of Gotland, in the Baltic, had a long tradition of erecting carved memorial stones. Some, dating from the 8th and 9th centuries, show an armed man on horseback arriving at a large building with several doors, met by a female figure holding out a drinking horn. The rider might be Odin because the horse has eight legs, as his was said to have; on the other hand, the rider is probably a dead warrior, not Odin the god of war that presided over Valhalla. On the memorial stones below this scene there are others, usually showing a warship or a battlefield, sometimes men feasting, and occasionally a flying figure that could be a valkyrie. The Gotland stones predate the Valhalla poems by several generations and come from a different region, yet they give visual expression to the same nexus of ideas about the warriors' paradise.

Jacqueline Simpson

See also Mythology

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Vegetative State

See Persistent Vegetative State

Viatical Settlements

The word *viatical* comes from the Latin word *viaticum,* which means "provisions for a long journey." A viatical settlement is the sale of a life insurance policy to a third party (the provider) at a discount (less than face value or death benefit). Ownership of the policy passes to the provider. The provider also becomes the new beneficiary. When the insured (viator) dies, the face value goes to the provider. The provider, who is usually a viatical settlement company, pays the premiums on the policy until the death of the viator. The provider may then securitize the viator's policy with other policies they have purchased and sell interests in the pool, similar to a mutual fund. The provider will require detailed information about the policy. They will want to see the viator's health records and will check up on the viator's health on a regular basis. At the viator's death, they will require a copy of the death certificate.

The viatical industry developed in the 1980s in response to the AIDS crisis. In the early years, viators (insured persons) were usually victims of AIDS who died within a few months of diagnosis and were in need of money to pay for their care

during those months. By the year 2000, AIDS victims were living longer due to new drug therapies, and the market shifted to include the chronically ill and elderly who needed funds to pay for assisted living. Another market has been wealthy elderly people who had purchased large policies when their children were young and who wanted some income from their non-income-producing life insurance policy, as they no longer needed to provide for minor children.

A viatical settlement is different than a clause in a life insurance policy to accelerated death benefits. Under the terms of the life insurance policy, the life insurance company pays out a percent of the policy's face value while the insured is still alive, and the remaining amount is paid to the policy's beneficiaries at the time of the insured's death. A person will usually receive greater financial consideration from a viatical settlement than from accelerated death benefits, but the original beneficiaries of the policy will receive nothing under a viatical settlement, whereas they will get some compensation when using accelerated death benefits. Ownership of the policy changes with a viatical settlement; it does not change with accelerated payments. In both cases, the insured usually receives more money than they would if they surrendered the policy.

Prior to 1996, the money received from a viatical settlement was taxed as ordinary income, whereas payments to a beneficiary at the death of the insured were received income tax-free. Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the payments received under a viatical settlement are received tax-free up to the amount paid in premiums over the life of the policy if the person receiving the proceeds has an illness or physical condition such that death can "reasonably be expected" to occur within 24 months, as estimated by a physician. The physician has to attest that there is at least a 70% chance that death will occur in the 24-month period. The letter is only needed if there is an IRS audit, but should be asked for at the time of the sale. In addition, the funds must be paid by a licensed viatical settlement provider if the state requires providers to be licensed or comply with the National Association of Insurance Commissioners (NAIC) standards. The NAIC model requires disclosure, escrow accounts, a rescission period, and pricing minimums. There are no restrictions on the use of the funds.

HIPAA also provides a tax-free benefit to a viator who is certified as chronically ill. To be chronically ill, a viator must be unable to perform at least two of the activities for daily living (such as eating, bathing, dressing, toileting, transferring) without substantial assistance for at least 90 days due to a loss of functional capacity or cognitive impairment (such as Alzheimer's disease). Unlike with the terminally ill, there is no restriction on the life expectancy of the viator, but the funds must be used to pay for or reimburse the cost of the viator's long-term care. There is a limit to the amount received tax-free if the money is not used to pay for long-term care.

The value of the policy is based on the age and medical condition of the viator, the type of insurance policy, the amount of the premiums and how often they are due, the financial rating of the life insurance company that issued the policy, and overall economic conditions. The viator needs to know if they are dealing with a provider (the viatical settlement company that is purchasing the policy) or a broker who is shopping the various providers looking for the best deal.

In addition to giving up all rights in the policy, the viator should know that this settlement may affect their eligibility for Medicaid, Supplemental Security Income (SSI), Aid to Families with Dependent Children (AFDC), and other programs, such as drug assistance. The lump sum received may put the person over the asset limit to qualify or may have to be used to reimburse the state.

The viator and the investor in viatical pools need to be aware of the possibility of fraud. Fraud usually takes one of four forms: (1) the insurance agent lying about viator's health when first selling the policy, (2) viators lying about their health, (3) viators defrauding providers, and (4) providers defrauding viators and investors. An example of the first type of fraud is an insurance agent lying to the insurance agency about the provider's health when the policy is purchased while working with a provider to sell the policy. An example of the second type is the insured lying on the application about an existing medical condition when the life insurance policy was purchased. The third type happens when the viator represents his health to the provider as being worse than it is,

thus gaining a higher amount from the purchase. The last type is the most frequent type of fraud. This is when providers and brokers deceive viators and investors by either giving the viator less money than they should receive or by selling a policy more than once to different investors. Viators should get multiple quotes to be sure they are getting a fair price.

Celia Ray Hayhoe

See also Burial Insurance; Economic Evaluation of Life; Estate Planning; Estate Tax; Life Insurance; Life Insurance Fraud

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Video Games

A video game is a form of interactive entertainment that involves a human user or multiple users and a user interface to produce visual information through an electronic device, such as an oscilloscope or a computer. Patented on December 14, 1948, the first commercial video game was available for sale in 1971. Since that time, video games have become a major cultural icon, influencing young and old alike. It is this influence that is cause for celebration as a source for enhancing visuomotor skills and perhaps even educational reform; video games also are subjected to intense public scrutiny.

Like other forms of entertainment, such as comic books, motion pictures, and even music and dancing, video games have been the target of both praise and controversy. The release of *Grand Theft Auto IV* (GTA IV) in April 2008 was greeted with waves of hysteria and hand-wringing by politicians, pundits, and some antimedia scholars concerning the effects that this game and games like it might have upon players. Much of the controversy surrounding GTA IV stems from its heavy and graphic use of violence and death-related themes. Although the actual impact of such games on players' behavior appears, in fact, to be negligible, the cultural unease that surrounds violent video games arguably stems in part from our fascination with and revulsion toward death, particularly human-precipitated homicide. Although GTA IV may be an unusually brutal video game in its portrayal of human violence, the theme of death in video games is hardly new, nor is the controversy surrounding death, and particularly violent death, in video games.

Death in Early Games

The first commercially successful video game was *Pong,* a simplistic, nonviolent, tennis-like game released by Atari. *Pong* was something of an anomaly because not even a hint of violence or death existed in the game. Even previous game designs with less commercial success, such as *Spacewar!,* involved battles of machine-on-machine violence that was ultimately won with the destruction or death of one of the players. Although nonviolent games like *Pong* retained a place in the video game industry, and continue to do so through the present day, games that included an allusion to death became more common and popular. Indeed, following *Pong,* most of the video games that reached surging popularity during the 1970s involved some form of cartoon-quality violence and death. Notable examples include *Space Invaders* and *Asteroids,* which featured machine-on-machine violence, as well as *Pac-Man* and *Centipede,* which involved nonhuman critters of various sorts attempting to shoot or eat each other. Other contemporary games, such as *Raiders of the Lost Ark,* started to show primitive versions of human-on-human violence.

The first major controversy over violence and death in video games occurred with the release of a game in 1976 entitled *Death Race*. Based on a movie of the same title, the game featured the player driving a car who would score points by running over screaming gremlins. Unfortunately due to the primitive graphics of the time, the gremlins looked too much like humans. Setting the stage for decades of panic, pundits began to

discuss the possible negative effects of playing video games, partially in response to the controversy generated by *Death Race*. Sales of the game *Death Race* may have been harmed by the controversy, although this early controversy is credited as creating publicity for video games more widely, resulting in increased sales overall.

The shooter game *Bezerk* generated some notice as the first game to actually kill players when Jeff Dailey and Peter Burkowski had heart attacks while playing the game in 1981 and 1982. The game itself hadn't done anything to cause the death of the players, and the timing of the heart attacks was likely coincidental. Nonetheless, the death of two young players during game play increased the notoriety of games at the time.

Death was at the center of most of these early games because it dictated the game flow. Although some nonviolent games like *Pong* existed, many games involved the player attempting to destroy or kill some other object in order to attain the highest score. A lasting legacy of this era that many modern critics of violent video games continue to erroneously assert is that players of modern games (such as GTA IV) "earn points" or "high scores" for committing violent acts. Most games phased out awarding scores altogether by the 1990s, but this idea of games and scores lingers from their early days in the 1970s and 1980s. Even relatively nonviolent games like *Frogger,* where players attempt to guide a frog across a river or street, end with the death of the player, that is, the character in the game, not the player himself or herself, except in the previous two cases.

Therefore, from their early days, video games became more intimately entwined with the subject of death than other media forms. Death-related themes certainly are common in literature and visual media, but they aren't necessary. Comedies, romances, and dramas may avoid death altogether in other media genres. As mentioned, there are also video games in which no allusion to death occurs, such as *Pong* and *Tetris,* but even in many nonviolent games, death is ultimately a necessary ingredient to signal the end of the game.

Death in Modern Games

Themes related to violence and death continued to expand in computer and video games in the 1980s and 1990s. Popular game platforms such as the "shooter" genre (e.g., *Castle Wolfenstein*) and role-playing games (e.g., *Final Fantasy*) began to emerge in the 1980s. As graphics slowly improved and game play began to feature more human-on-human violence, controversy over violence in video games continued. Antimedia activists were particularly concerned about the interactive nature of video games, suggesting that such games may increase aggression more than television was alleged to do, although such concerns were never well supported by empirical data. During the same period, hysteria roiled over the role-playing game *Dungeons and Dragons* (D&D), particularly because this game was more interactive than video games. D&D was posited to cause aggression, suicidal ideation, and delusions. The panic ultimately culminated in a popular made-for-television movie, *Mazes and Monsters,* which implied that D&D might cause psychosis. Given that D&D was a fairly static platform with relatively few changes over time, fervor over the game's supposed ill effects eventually vanished in the absence of any wave of mentally ill players. However, video games continue to evolve, become more graphic and violent, and reach out to a greater numbers of new players. Storylines are also becoming more complex and artistic, and demographics are changing, with adults increasingly becoming the target audience of many games. So although games like *Castle Wolfenstein* that provoked great controversy in the 1980s might seem harmless and quaint by today's standards, they have been replaced by increasingly graphic and sophisticated games.

About the early games, some critics (as with television) complained that the consequences of violence appeared unrealistic. However, once the violence became more realistic, the criticism only increased. Games from the early 1990s, such as *Streetfighter, Mortal Kombat,* and *Doom,* portrayed increasingly bloody consequences of violence and increasingly gained criticism from society's elders. Some critics began positing the existence of juvenile "superpredators" who, raised on violent media, would set off waves of violent crime. Oddly enough, this period in which video games with violence and death themes surged in popularity, rather than sparking a generation of "superpredators" saw precipitous declines in youth and general societal violence to levels not seen

since the 1960s. Indeed, looking at the data on youth violence and video games sales for the years 1996 to 2005 (the only years that both sets of data are available), we find that the relationship between youth violence and video game sales is $r = -.95$, almost perfect, but in the wrong direction. Thus, the video game violence controversy appears to be something of a controversy in search of a crisis. It is quite likely that the controversy is being driven, not by any practical reality, but rather by societal unease with themes of death and violence included in many video games.

Portrayals of Death in Video Games

As with television, an early criticism of video games was that death was not portrayed in a realistic fashion. In early arcade games, another quarter easily revived one's character. Death, in effect, was no big deal; it was all part of the game. Some of this was due to the absence of an integral storyline. Games such as *Space Invaders* or even *Castle Wolfenstein* lacked complex, integral stories. By and large, the technology simply didn't allow for more complex storylines. This early period, once again, probably continues to harm public perception of video games, as some may fail to equate video games with the increasing levels of artistic expression seen in more modern games. Put another way, an early game like *Space Invaders* was "just a game," with no pretensions to artistic credibility. However, more modern games like GTA IV, *Bioshock,* and *Mass Effect* are regularly hailed for their detailed and artistic storylines. This is not a minor issue because the status of video games as either "just games" or valid artistic expression became a central focus for legislation seeking to restrict the sale of video games. This would have brought video games the unique status of being the only form of media (aside from pornography) to be directly regulated or censored by government legislation. So far, the artistic elements of modern video games, along with limited empirical support in the scientific literature claiming the negative effects of video games, have been instrumental in assuring video games the First Amendment protection of free speech in court cases.

Even in more modern action games, death tends to be treated in a transient way. Specifically, to keep the action going, individual deaths come and go quickly, with players moving on to the next target. Relatively little emotional attachment is formed between the player and the majority of characters in the game. This differs from other media in which death may be treated dramatically for emotional effect. Certainly there are movies or television shows in which death, particularly of bad guys, is treated transiently (particularly in the action genre), but this is more common for video games because fast action is generally required to maintain game play. There are exceptions to this. Several of the most modern games, such as GTA IV and *Call of Duty IV,* use "cut scenes" between periods of action to portray the death of important game characters as emotionally laden events. Typically these cut scenes come as "chapter breaks" in the game and serve to move the story forward. Actions occurring during cut scenes are typically not under player control, although players are allowed to play out one integral character's death moment in the game *Call of Duty IV.* The game *Max Payne* was well regarded for its emotional storyline, in which the brutal murder of the main character's family was played out for emotional effect, setting the dreary mood for the game.

Death, however, continues to be fairly transient in most video games. Following death, the player only needs to restart the game, oftentimes from a previously saved location. Although players may grow attached to their characters, particularly in role-playing games such as *World of Warcraft,* the lack of permanency associated with death in video games likely blunts the emotional impact of death. Thus, death in video games may have less impact than in other forms of media in which the death of a character is, barring improbable plot twists, permanent.

The heavy involvement of death-related themes and violence in some video games is likely to keep video games at the center of public controversy for some time to come, at least until a new media replaces video games in the public consciousness. The actual "harm" caused by exposure to such games appears to be negligible, likely repeating the cycle of antimedia hysteria that follows in the wake of new media, particularly those that explore violence and death-related themes. Such controversies likely have less to do with science and more

to do with our own human unease with subjects related to death, dying, and violence, while at the same time we remain fascinated by them.

Christopher J. Ferguson

See also Depictions of Death in Television and the Movies; Pornography, Portrayals of Death in; Zombies, Revenants, Vampires, and Reanimated Corpses

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Wakes and Visitation

The wake is a watch kept by the living over a deceased person before burial takes place. Formerly held as a matter of course when a death occurred, the wake has become a thing of the past in many Western societies in the course of the last half a century, while in others it has been transformed into a family-centered, semiprivate event. Where it has retained its traditional features and functions, it is a highly structured public event, held in the presence of the deceased, in which the deceased's family, kin, and community take part. The duration of the wake and the extent of the ceremony involved reflects the deceased's status in society and the manner of his or her death. In traditional communities, the circumstances of death are reflected in a ceremonial wake. When a person has died a natural death, the wake can be an elaborate event extending over a couple of days. In the past, where death was due to violence, if death had resulted from drowning, if it had occurred before birth (stillbirth), or if the person remained unbaptized when death intervened, the wake could be a scaled-down affair, or it might even be dispensed with, thus reflecting the perceived anomalous nature of the death and the uncertainty about the deceased's status in the afterlife. Nowadays, the tragic deaths of young and old can be occasions for elaborate religious and public ceremonies and intense public participation in the funerary ritual.

After the moment of death passed, the deceased is usually left undisturbed, with his or her face uncovered for a number of hours to ensure that death has actually occurred and to allow rigor mortis to set in. In some cultures this period is thought of as an interval when the soul makes a number of farewell journeys before returning to the body to bid it a final good-bye as it departs forever from this life. When the person has died at home, the commencement of this period of solitude for the deceased is regarded as the moment when the household commences its preparations for the impending wake. This includes making arrangements for a supply of wake goods, especially food and drink, to be made available in the house, but it can also involve the provision of mortuary clothes for the deceased and the ordering of the coffin. The preparations for the wake also involve the rearrangement of space in the house to cater for the viewing of the corpse by family and community, and to enable people to pray for the deceased. The home will also facilitate the dispensing of hospitality to the wake guests, and, where the customs still prevail, will enable the participants to engage in ritual lamentation for the dead and the performance of wake games or other forms of amusement while the wake is in progress. But as the deceased is the central figure of the wake, he or she has to be prepared and readied for public viewing before the wake can begin.

Body Preparation

Whether performed by family or friends or by professional undertakers, the laying out of the corpse involves the ritual preparation of the body by

washing, grooming, and clothing for public display. In traditional societies where the laying out was done by community members, the manner of preparation of a deceased person was strictly codified. Laying out was usually done by women who were versed in the protocol of dealing with a deceased person, but in some places men participated in the preparation of male corpses, while children, male and female, were normally laid out by women. The preparation of the corpse was usually done in silence and movement around the body was from left to right, with the washing commencing at the head and moving clockwise to the feet and then back to the head on the left side. Movement across a corpse was avoided, and domestic animals such as cats and dogs were removed from the house while the wake was in progress. The water and other items used in the preparation of the corpse were carefully disposed of after use, often being consigned to the earth, as the corpse would later be. The deceased was then completely dressed, from head to toe, usually in special clothing, which, in different societies, could be elaborate depending on the secular or religious role or social standing of the deceased or his or her family. The color of the death clothes, such as the use of white garments for young children and unmarried women, might also reflect the age or marital status of the deceased. In some societies it was customary for the deceased to wear shoes, indicative of a belief that death involved a journey to the afterlife. Nowadays, especially in Western societies, people are often dressed in their own clothes, and it is not uncommon for young men to wear the jersey of their favorite football team.

When the remains have been properly prepared for viewing, the deceased is laid out in a supine position with joined hands resting on his or her breast. In Roman Catholic tradition, a crucifix and rosary beads—usually those belonging to the deceased—are placed in the deceased's joined hands. Depending on the customs of the society, the corpse could be placed on a bed, on a hard flat surface such as a table, on a mat on the floor, or in the coffin. The corpse is positioned in the room so that those attending the wake can pay their respects. In Roman Catholic tradition, at least one blessed wax candle is kept burning by the corpse for the duration of the wake. This tradition symbolizes the perpetual light to which the deceased is called. Aromatic plants or other objects might also be placed around the corpse. When all of these measures—temporal, spatial, cleansing, and victualing—are in place, the wake for the dead could begin.

Once the wake has commenced, the deceased has symbolically entered upon the journey to the afterlife. As the wake is generally held in the deceased's presence, his or her transition thus takes place in the company of family and community and is facilitated by their engagement in various procedures involving lamentation, revelry, prayerfulness, and reconciliation in the course of the wake. In many societies, the commencement of the wake was the moment when the ritual lament for the dead took place, usually performed by family members.

The Lamentation

The expression of grief is a natural human reaction in the presence of death. The ritualization of that emotion into a stylized poetic expression of mourning is an ancient cultural inheritance in many parts of the world. While no longer part of the funeral obsequies in Western societies, it is evident that there were specific junctures during the wake when the lamentation was performed and that these corresponded to certain key moments of the obsequies—such as the commencement of the wake, the arrival of family members to view the corpse and partake in the wake, the coffining of the corpse, the removal of the corpse from the house, and the departure of the funeral cortege. The lament was usually performed by women who were skilled in the art of lamentation and, as lamenting the dead was considered an obligation as well as a custom in traditional societies, talented mourners would be hired if no family member was able to fulfill the duty of ritual mourning. The lamentation took place in the presence of the corpse with the lamenting women usually standing and swaying over the deceased, often clapping their hands while performing. The lament consisted of verses chanted in praise of the deceased by the leading keening woman, who then led a coral cry in which the other lamenters and the wake audience joined. This communal lamentation is often described as having a cathartic effect on family and community.

Lamentation was an integral part of the wake ceremony in many parts of the world, and also was revelry and the wake meal, which often contributed

to the quasi-festive atmosphere to the wake. If the deceased was considered a great loss, however—if, for example, the mother or father of a young family had died—then the wake was normally a solemn and sad event.

The Wake: A Celebration of One's Life

In societies where the deceased is considered to be the wake host, the wake guests are thought to partake of his or her hospitality. This may have a basis in reality in cases where the deceased has left instructions about the duration of the wake and had made provision for a supply of food and refreshments to be served to those attending. Wake victuals are normally acquired, usually through purchase and the receipt as gifts from friends and neighbors after the death has taken place, and any food remaining after the wake is disposed of after the corpse had been removed from the house. Traditionally, the food dispensed during the wake was prepared and served by neighbors and friends rather than by the immediate family. The family's main role during the wake was to receive the wake guests and to accept their condolences in honor of the deceased.

It was and is understood that each wake participant will be offered a meal at the house of the wake and a refusal to accept refreshments could be seen as a rejection of the hospitality intended on behalf of the deceased. The meal might be served in the presence of the corpse and the symbolic participation of the deceased in the repast could be signaled by the setting of a place for him or her at table. The festive type of food that still tends to be served at wake events also often confers a quasi-celebratory atmosphere on the occasion, especially if the deceased has passed away after a long and fulfilled life. The provision of alcoholic beverages arguably contributes most to the festive nature of wakes. The provision of alcoholic drink for wake participants was a matter of ongoing concern for the Christian church authorities for many centuries. They consistently forbade bereaved families to provide alcoholic beverages at wakes in order to rid the occasion of behavior they considered inappropriate. Their efforts remained largely unsuccessful for a long period of time, and in the end it was changing attitudes in society toward alcohol consumption and the wake event itself that altered the situation, as late as the 20th century in some places.

Wake Games

Wake games were an integral part of wake procedure in many parts of Europe through the centuries. The playing of games at wakes was known throughout much of the Continent—from Ireland in the west to Hungary, Romania, and the Ukraine in the east, and from Scandinavia in the north to Italy in the south. The *Indiculus Superstitionum,* a list of superstitions compiled by clerics in the year 743, indicates that the clergy at that time were actively condemning *sacrilegia super defunctos* (abuses over the dead). The singing of devilish songs over the dead at wakes by night, the sporting and dancing, and also the feasting and drinking that also took place were condemned by the German cleric Burchardt of Worms, about the year 1000. In later times, the German bishops and their counterparts in Norway, the Balkans region, France, England, Ireland, Scotland, the Isle of Man and elsewhere, also condemned such practices. In Ireland, wake games were repeatedly condemned by the Catholic Church authorities over a period of about four centuries, until they eventually disappeared throughout the course of the 20th century.

Another aspect of wakes, especially in the Roman Catholic tradition, was and is the saying of prayers at intervals during the event. These prayers consist usually of the rosary, which is recited by family and community in the presence of the deceased. Other prayers for the deceased, and for the bereaved family and community, are also said during the wake. The wake ends with the coffining of the corpse and the ritual removal of the deceased from the house when the journey to the church or cemetery begins.

The wake for the dead continues to hold contemporary significance. With its traditional elements of mourning and license and, in some contexts, its prayerful commendation of the deceased to the Christian afterlife, it may be thought of as promoting reconciliation between the deceased and the living, between family and community, and between a Christian and Christian notions of death and the afterlife. With the renewed recognition of the importance of the wake, and especially the viewing of the corpse for the process of grieving, the wake

for the dead is once more gaining in popularity, albeit in a modified form, in some Western societies. Modern embalming techniques are leading to a move away from funeral homes as people are prepared to hold the wake for the deceased in his or her own home—even for a short time—prior to burial so that the funeral can commence from there. This is increasingly seen as a more meaningful way of dealing with the crisis of death.

Patricia Lysaght

See also Bereavement, Grief, and Morning; Death, Philosophical Perspectives; Funerals; Lamentations; Transcending Death

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War Deaths

As a social phenomenon, war is undoubtedly to be met at any time and in any place where the presence of the human species is found. In historical times, the art of warfare evolved into a science of warfare, and its specialists acquired a prestigious status in society. As Georges Dumézil put it, along with the laborer and the priest, the soldier was to become a prominent figure in Indo-European civilization. And there's no suggestion of the absence of this figure in other civilizations as well, even those that were styled as pacifist societies. The German general Claus von Clausewitz coined the famous adage that "war is the continuation of politics with other means," and this pertains to death. War has as its goal to produce dead people, first the death of military people, but also the death of civilians who are present in and around the area of battle. In contemporary warfare, the risk of being killed is as high or even higher for civilians as it is for soldiers.

War as a Lethal Activity

Prior to the time of the invention and implementation of gunpowder around the end of the Middle Ages, the number of dead by feat of war seems to have been rather low. But guns and also the assembling of vast armies were to exact a growing number of war casualties. In most cases, the wounded would face death within a short period of time. For most of these individuals, their fate was undoubtedly worse than that of those who died instantly from their wounds. Along with bullets and knives, gangrene was one of the main purveyors of death in time of war.

The lot of the wounded when neither painkillers, antibiotics, nor anesthetics existed was certainly a gruesome one. To the death by wounds, specific illnesses must be added, such as dysentery or typhoid fever, to which a great number of warriors were to succumb. Perhaps the toll paid to these epidemics has been higher than that paid to the direct effects of the fighting itself. In war, casualties do not mean only men and women killed in combat, but also the wounded and sick whose death may occur much later. There are also the victims of mass slaughter linked to the war operations, and even those victims for whom death penalties were carried out because of desertion or cowardness during battle.

Civilian casualties must be added to this list. Terror air raids conducted during World War II account for a large amount of these victims, adding of course the displacement of huge throngs in

the zones of combat, and voluntary mass slaughters, the *Shoah* being the perfect example.

The total number of dead casualties in the wars conducted at the time of Napoleon was high, an estimated 4 million casualties. But it is from the second half of the 19th century that the concept of "war of attrition" gained relevance. The American Civil War (1861–1865) is said to have cost the country some 620,000 dead, or about 2% of the total American population in 1861. The estimate of 258,000 Confederate war dead derives from incomplete data, because the war was mostly fought in the South and the number of Southern civilian deaths is unknown and not included.

During World War I, the United Kingdom suffered about 885,000 dead, France 1.4 million, Germany about 2 million, and the United States slightly fewer than 120,000. To these figures must be added the dead totals from the other belligerent states, namely those of Russia. For Russia, however, the total will never be known because World War I occurred concomitantly with the Russian Revolution and the Russian Civil War.

World War II was to prove much more lethal: Japan lost 2.1 million, China 3.8 million, Germany 5.5 million, and the Soviet Union an estimated 10.7 million. Taking into account the civilian victims and the prisoner of war (POW) dead, it has been said that the total Soviet Union dead in the war amounted to more than 20 million people. The victims of the Shoah, around 6 million, must be added to these numbers. No doubt the 20th century can be said to have been the more murderous one, ending with the Rwanda genocide of 1994.

Managing the Slain Bodies

The fate awaiting the corpses of war is multifarious. A minority of them will be cleanly buried, with, in some instances, full military honors. Then a vast number of war dead will be placed into collective graves as a provisional measure taken in order to protect the corpses and also to guard against hygienic problems. In case of emergency, the dead will be burned on the spot, a decision made against the regulations of the majority of religious denominations. For those counted among the missing in action, in most cases the bodies will never be recovered.

For armies in the field, the growing number of dead casualties poses acute problems of management. Decisions must be made quickly, for the presence of dead and decaying bodies on the battlefield or in bombed buildings gives way to a high risk of epidemics. In the modern attrition wars, many soldiers die of disease, forcing the authorities to cope with this additional and significant loss of fighting ability. And many others die in POW camps.

Administration services, with a numerous personnel, are required to deal with the dead in the new form of warfare, namely mechanized. The first duty is to identify the dead, thereby giving them back their names. The second task consists of informing the families of the dead soldier's fate. Thereafter is the gathering of the corpses to be buried in cemeteries or collective graves. On occasion, orders would be given to combating units to get rid of the corpses by burning them in heaps. These duties last for a long time and even after the war has ended, as is so eloquently described by Bertrand Tavernier's 1988 film, *La Vie et rien d'Autre* [*Life and Nothing Else*]. For then came the time of exhuming the dead, of trying once again to identify the dead, of reuniting them in definitive cemeteries (to be administered by special offices, like the Commonwealth Graves Commission), and to organize the appropriate ritual ceremonies. This often went through the reclaiming of the dead bodies by their close relations, so that a private ceremony could be conducted.

Piaculary Expressions

Either personal or collective, the rites conducted were properly of the piaculary type. *Piaculary* means expiatory, atonement, or making amends, and for the survivors, these rites provide an occasion for expressing a normative feeling of expiation toward the dead warriors. The main problem is that of the bereavement. For a dead soldier's family, it is hard to go through the bereaving period in the absence of a grave where they can be sure of the presence of the loved one. It is on this grave that the funeral rites can be performed. But where the corpse is not involved, the ordinary three stages of the ritualizing process are condensed into one lone staging to include the farewell rites, the translation rites, and the welcoming rites. However, when family members and close friends are able to attend the transfer of the mortal remains from a provisional burial place to a definitive one, then the second stage of the committal process can

also be performed, be it in symbolic way if the transfer journey has been reduced to a short procession on the graveyard ground.

The Atonement Process

The atonement dimension of the ritual process is twofold. First there is atonement for the killing itself: The close ones have not been able to prevent the beloved one (in the vast majority of cases a male in the prime of his life) to fall on the battlefield or to die in a hospital from wounds or diseases resulting from his presence on the front. Even when the patriotic cause is endorsed by the soldier's family, the glorious dead nevertheless remains dead, whose death should not have occurred at so fresh an age, and one must ask for some forgiveness regarding this grievous event. For the surviving friends of the dead, a certain sense of injustice may be experienced, such as asking, "Why him and not me?" This feeling has proved rather common among the survivors of the extermination camps, but it has also occurred among those who went more or less safely though the terrible ordeals of combat.

The second part of the atonement on behalf of the close relatives of the dead lies in the provisional burial on the battlefield, the equivalent to an indecent way of disposing with the dead body, more so when no mortuary rites have been performed. This indecency must be redressed, because what happened to the dead body can be accounted for an undue wrong. Thus in many cases, the mortuary rites held at the definitive grave take the form of a public ceremony, often of a mixed religious-civic character. In an attempt to reward the glorious dead hero with a reparation gesture, the ceremony may be grandiose. The burial in the hallowed place of the Tomb of the Unknowns is the most striking illustration of this proceeding. In this special ritual staging, extolling this highest collective heroism is mixed with the deepest collective atonement. A special mention must be made of the fallen soldiers whose corpses had been cremated, often against their religious convictions. And this requires a specific kind of repentance, thereby increasing the piaculary aspect of the ritual.

Monument to the Glorious Dead

After the wars of the modern times, societies generally proclaimed that all those who died during combat were to be thought of as glorious. Even those who ambushed (the French *embusqués*) were drafted in the glorious host. Those who do not qualify for this membership, such as deserters, cowards, and mutineers shot as examples, were carefully expelled from all official references. Their names would not appear on the countless monuments dedicated to the memories of the official glorious dead. These monuments were erected in the wake of the wars, whether these were won or lost, in the centers of towns or villages, in local civilian cemeteries, or on the spots of particularly hard fighting.

War monuments, especially after World War I, became a part of the human landscape. Ceremonies are held around them on remembrance days, attended by veterans, local authorities, bereaved families, schoolchildren, and members of patriotic associations, for example. The monuments to the glorious dead are considered symbols of national heroism, and they serve as rallying spots for patriots, sometimes representing the spirit of vengeance as well. For the militants of patriotic causes, the glorious dead whose names were inscribed on the monuments testify to the collective sacrifice of which they were a part. In proclaiming that this sacrifice should not be in vain, the politicians enlisted the war dead in political debates, either of a pacifist stance or a revengeful one.

Glorifying War Dead

In some countries, names of the deceased are given to streets and public squares, thus representing another method for glorifying the dead. Glory is a concept that transcends all the petty impediments hindering the conduct of a truly glorious war. The glorious dead, before being killed, often suffered much in their trenches, their boats, or their planes, but the fact that they died for their homeland pushes all these ordeals into oblivion. What is given in the official discourse is their glory. Hence, imagine the shock experienced by the readers of books dealing with the unglorious, dirty side of warfare, such as *Le Feu* by the French Henri Barbusse or *Opfergang* by the German Fritz von Unruh.

National shrines dedicated to the glorious dead represent a similar ideology, albeit on a higher level as local war monuments. Verdun, with its "trench of the bayonets," is an example of such places of national worship.

In some cases, the cult devoted to the glorious dead is staged at a national place of honor, such as the Tomb of the Unknowns or the British Cenotaph, located in Whitehall, London. This simple marble monument, suggesting a coffin borne by a high pedestal, displays on one of its faces the simple words, "The Glorious Dead," symbolizing all the combat victims of the British Empire since World War I. On the nearest Sunday to November 11, a grandiose staged ceremony takes place at the site. Its rituality seems immutable: First, music is played by a mixture of various military bands, then the Anglican Bishop of London delivers a short homily, then the Queen and the members of the Royal Family, followed by the prime minister and other political leaders, lay wreaths on the Cenotaph's feet, followed by the military chiefs and the High Commissioners of the Commonwealth Nations, to end with the leader and other members of the Royal Legion of veterans. After the official part of the event, a long cortege of veterans and veteran-related people passes along the Cenotaph in military fashion. What is remarkable is the blend of civic and religious pageantry, the last one being restricted to the official Church of England, though representatives of other denominations, led by the Catholic primate, also attend the ceremony. This funeral ritual at the national and international level is clearly a piaculary ceremony. That is, the deceased gave their lives, we praise them for their sacrifice, but we also seek their forgiveness.

The Unknown Soldier

In some countries, after the end of World War I, a corpse has been chosen from the unidentified war dead to become the unknown soldier. This was later transferred, along with a display of emotional military pageantry, to a national shrine in a highly symbolic place, such as the Arc de Triomphe in Paris or the Congress Column in Brussels. The unknown soldier thus becomes the son of mothers who could not find their own sons, a metonym for all the fallen soldiers who gave their lives to protect their homeland, thereby transforming mothers into a powerful living metaphor. The rites used to evoke the presence of this unidentified corpse bear various aspects of funeral rites in general, which are raised to the status of a commemorative ceremony, at the same time atoning for all these "glorious dead" and exalting the national community.

What remains of the versions of the tomb of the unknown soldier in various countries is a place of meditation for visiting heads of state or government. The surviving ritual (including other war monuments of national significance), the laying of a wreath, functions to allow homage to be rendered. That this homage is paid to the glorious dead of ancient, almost forgotten wars is meaningful, for as the French philosopher Alain once announced, the dead govern the living, and this is true as well of individuals as of whole nations.

Claude Javeau

See also Gold Star Mothers; Memorial Day; Memorials, War; Survivor Guilt; Tomb of the Unknowns

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Wax Museums

Well before Madame Tussaud's artistic brilliance came onto the London art scene in the late 1700s, societies used waxworks to immortalize their culture and the deceased. Historians trace the earliest forms of wax figures to around 3000 B.C.E., in what is now modern India. Egyptians used the wax effigy as a way to retain the soul of the person after death. The Greeks and Romans used wax effigies in funeral processions and particularly for displaying prominent political figures of the time. Early, and to some extent contemporary, Christians often used wax figures to depict iconic people, such as Jesus and Mary. This entry examines the history of the contemporary wax museum

and the functions of the contemporary wax museum in modern society.

Although the contemporary wax museum does not serve the religious or spiritual functions it once did, it still has significant social, cultural, historical, and political functions for society. The content and meaning of the wax statue in contemporary society has changed since the times of death masks and the religious offerings of wax figures during the Middle Ages. However, the wax museum—the medium for displaying waxworks in contemporary society—still immortalizes the deceased and crystallizes pieces of its society's history and culture.

Madame Tussaud and the Contemporary Wax Museum

Modern wax museums evolved from the traveling wax curators of Britain's Victorian Age. Like the state fair of today, the traveling display gave the general public an opportunity to view famous people they had only heard or read about. As a form of entertainment, Phillipe Curtius, Madame Tussaud's mentor, initially designed his wax displays for the elite, and as an opportunity for the public to interact with people they would not normally meet. Wax museums allowed the wealthy to pretend they were a guest of some royal figure or famous celebrity. For example, one of Curtius's most popular attractions was the representation of King Louis XIV and Marie Antoinette holding a dinner party, where the public could pay their entrance fee and sit with royalty.

Today, the name Madame Tussaud is synonymous with wax figures. Born Marie Grosholz in 1761, in Strasborg, France, she became an assistant to Phillipe Curtius, from whom she learned wax modeling. Tussaud knew many of the leading figures of pre-Revolutionary Paris and indeed was invited to live at the Royal Court in Versailles to be the art tutor to King Louis XVI's sister. Her sympathies toward the king led to her incarceration during the Revolution, and she was forced to make death masks of the royalty she once adored. After her release, she returned to work for Curtius and inherited his collection of waxworks after his death in 1794. In 1802, she went to London and, prevented from returning to France by the Napoleonic Wars, exhibited her waxworks collection throughout Great Britain and Ireland.

Madame Tussaud's attractions are particularly adept at appealing to the local culture, while also providing the opportunity to see wax figures of people from around the world. The London collection houses figures of British royalty and politicians, but also includes figures such as Albert Einstein and Pablo Picasso, while the Las Vegas collection houses the Blue Man Group as well as popular sports icons and movie stars.

The Functions of the Wax Museum in Contemporary Society

Wax museums function to reproduce, crystallize, display, and construct social, cultural, and political images. Commemoration of heroes and villains reflects a society's value system. In this area, it is suggested that the hero image represents a positive deviation from the society's general value system, whereas the villain image represents the negative deviation. As the contemporary wax museum commemorates its heroes and villains, it is also reinforcing a collective social image. In a sense, heroes and heroic events provide social solidarity among individuals.

In similar fashion, the wax museums display waxworks of the collective image of the villain embodied in political leaders, such as Adolf Hitler and Benito Mussolini, and social villains, such as Anton LaVey. Some wax museums, such as the Criminals Hall of Fame Wax Museum in Niagara Falls, Ontario, focus exclusively on displays of the villain, such as Al Capone, Charles Manson, and Jesse James. Although the museum is intended to entertain, it also serves to reinforce the cultural norms of society and crystallizes the collective image. The wax museum is a reproduction of culture, confirming the relevance through its cultural images. The Museo de Cera in Veracruz, Mexico, for example, reinforces the culture of contemporary Mexico with waxworks of public figures of sports, politics, and the arts.

Wax museums allow for members of society to see who society vilifies and idealizes, creating an opportunity for social control over members. Visitors to the Famous Criminals Hall of Fame Wax Museum can see the image of Jeffery Dahmer looking into a refrigerator with human body parts. Criminal wax museums can vivify and show the deviant behavior by the significant effect of three-dimensional construction of wax images.

The display of heroes and villains in wax museums serves to identify boundaries of social control.

The Human Imagery Museum in Nakhonpathom, Thailand, promotes and propagates Thai society. Similarly, the National Wax Museum of China was commissioned by the Chinese government to display collective images of China's political and social leaders. In the West, the wax nativity scene in Madame Tussauds in London epitomizes this idea. In each of these examples, the wax museum reinforces the political and cultural status quo. But contemporary wax museums also provide a collective memory while portraying historical shifts in moral boundaries. The Great National Blacks Wax Museum located in Baltimore, Maryland, represents a collective memory through the representation of the history of race relations in America. Similarly, the Museo Historico de Cera in Buenos Aires, Argentina, displays numerous waxworks depicting the traditions of the culture of the region prior to Spanish colonization and the violent battles between the Querandi natives and the Spaniards during the process of colonization.

Symbolic Immortality

The wax museum offers symbolic immortality. Photographs provide one way of continuing life after death in symbolic ways, but for public figures, the wax museum is a medium for individual symbolic immortality. In portraying symbolic immortality, monuments transmit culture from one generation to the next. The wax statues of Babe Ruth and Albert Einstein in the Royal London Wax Museum in British Columbia, Canada; Joe Louis and Jack Dempsey in the popular Wax Museum at Fisherman's Wharf in San Francisco; and Duke Ellington and Bob Marley in Madame Tussauds in New York represent such symbolic immortality.

In summary, the wax museum embodies a society's value system, its historical, cultural, social, and political images. Ultimately, the contemporary wax museum is a rich chronicle, a commemoration of society's heroes and villains that resonates with society's collective conscience through its symbolic images. It allows people to interact with history's public figures. Through the wax immortalization of heroic and villainous people, the contemporary wax museum will continue to transmit a society's cultural, social, and political chronicles.

Jason Milne and Steven J. Seiler

See also Commodification of Death; Death Mask; Museums of Death; Symbolic Immortality

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Widows and Widowers

Widows and widowers are women and men who have survived the death of their spouse. Widowhood may be conceptualized as both a life transition and a personal status. Widowhood is a transitional event because the loss of a spouse is typically accompanied by high levels of psychological distress as the newly bereaved person adjusts to life without one's spouse. Yet widowhood also may be conceptualized as an enduring social role or identity, just as "married person" is a social role. Although the transition to widowhood is often associated with grief, depressive symptoms, and declines in physical health, most bereaved spouses are resilient and return to preloss levels of functioning within two years following their loss.

The likelihood of becoming widowed and of remaining widowed and the consequences of spousal loss vary widely by gender, age, and sociohistorical context. Gender is one of the most powerful influences on the experience of widowhood. In all developed and nearly all developing nations, women are more likely than men to outlive their spouse, reflecting men's higher rates of mortality and the tendency of women to marry men slightly older than themselves. Widowhood is also an older women's issue; life expectancy has increased steadily over the past century, and spousal loss overwhelmingly

befalls older adults. As such, widowhood has important consequences for the physical, economic, and psychological well-being of older adults.

Gendered Patterns of Widowhood

Highly visible images of distraught widows and widowers often feature the young—the youthful brides of fallen soldiers in the Iraq war or the junior executives who lost their wives on September 11. Yet widowhood today is a transition overwhelmingly experienced by people age 65 and older. Of the 900,000 people who become widowed annually in the United States today, nearly three-quarters of them are age 65 or older. Widowhood patterns mirror mortality patterns. The death rate, or the number of all people who die in a given year per 100,000 people in the population, increases sharply beyond age 65 (see Figure 1). Life expectancy at birth today is 76 for men and 80 for women, so women are much more likely than men to outlive their spouse.

Women also are more likely to remain widowed, given widowers' greater propensity to remarry. Among people age 65 to 74 in 2006, 26.3% of women and just 7.3% of men are widowed. These proportions jump to 58.2% of women and 20.5% of men age 75 and older (see Figure 2).

Widows are far less likely than widowers to remarry because of the death of opposite sex peers. Among men and women age 65 and older in the United States, the sex ratio is 1.5 women per every man. By age 85, this ratio is more than 3 women per every man. As a result, few widows have the opportunity to remarry. Additionally, cultural norms encourage men to marry women younger than themselves, so widowed men may opt to remarry a younger woman, whereas older widows do not typically have access to a similarly expanded pool of potential spouses. Recent studies also reveal that women in contemporary Western nations have a weaker desire to remarry; many women report that they do not want to resume the homemaking and caregiving chores that often accompany marriage.

The Personal Consequences of Widowhood

Widowhood often is accompanied by emotional distress, physical symptoms, compromised health behaviors, potentially disruptive residential relocations, and economic strains triggered by both the direct costs of medical care and funeral arrangements at the end of a spouse's life, as well as the loss of the (working age) spouse's income. In this section, we describe the consequences of widowhood for older men and women. However, it is

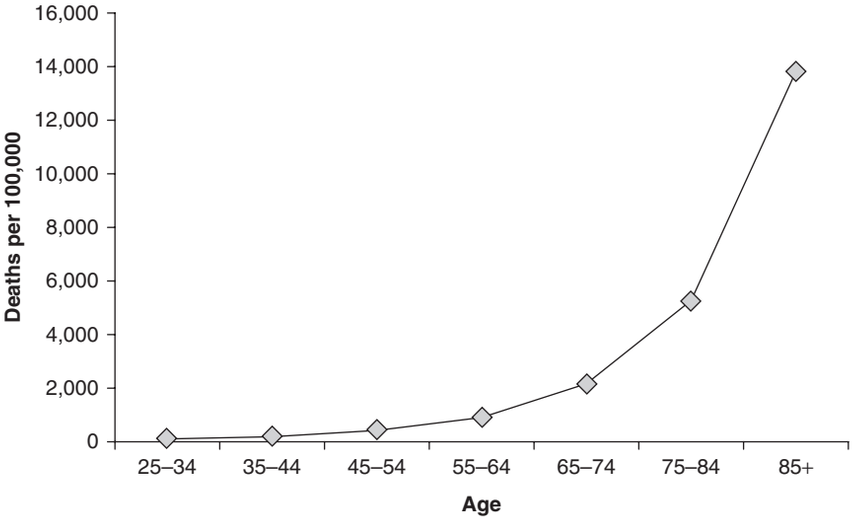

Figure 1 Death Rates by Age (All Causes), United States, 2004

Source: Deaths: Final Data for 2004 (August 21, 2007), by *National Vital Statistics Reports, 55*(19), pp. 1–119.

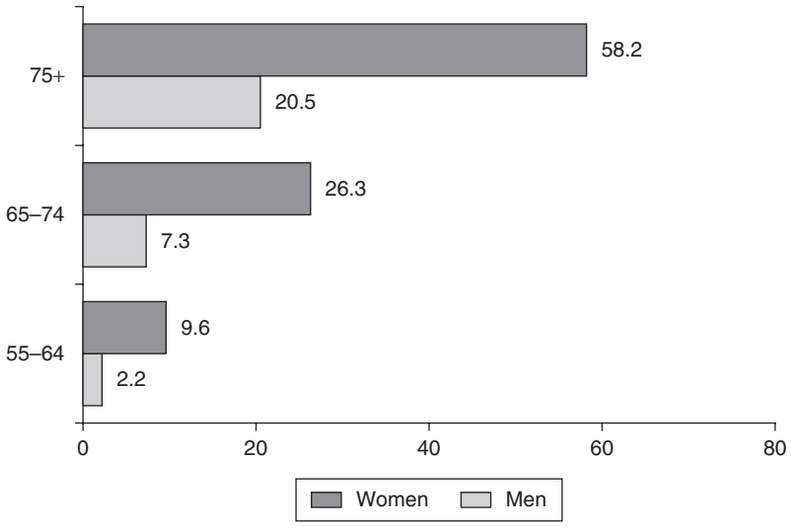

Figure 2 Proportion Widowed, by Age and Gender, United States, 2006

Source: Table A1: Marital Status of People 15 Years and Over, by Age, Sex, Personal Earnings, Race, and Hispanic Origin, 2006 (pp. 20–547) from *America's Families and Living Arrangements: 2006,* by U.S. Census Bureau, Current Population Reports (March 27, 2007).

important to note first that the widowhood experience is different for older and younger adults.

The age at which one experiences a major life transition shapes both the nature and context of the event. Life events that occur unexpectedly or are "off-time" (that is, earlier or later than one's peers) are particularly distressing. Youthful deaths typically are unexpected, leaving the young bereaved spouse little time to prepare psychologically or financially. Many younger widows and widowers face the challenge of raising children on their own, often while working full time. Many may be robbed of a long future with their spouse, and few have peers to turn to for empathy and support, as spousal loss is rare among young people.

By contrast, most older people experience the loss of their spouse after decades of marriage. They have raised their children, celebrated the births of their grandchildren, and have enjoyed at least a few years of relaxation together after retiring from the workforce. For most older spouses, widowhood comes "on time," rather than prematurely. Older people are often prepared for the transition, and they have friends and peers they can turn to for emotional strength, practical support, and camaraderie. Older adults also differ from their younger counterparts in how they respond emotionally to stress. Psychologists document that older adults have lower levels of "emotional reactivity." This means that they have a heightened capacity to regulate their emotions, and they report less extreme emotional responses than do younger people. As a result, their grief reactions tend to be less intense and much shorter lived than those experienced by young adult or midlife widows and widowers.

Who Adjusts Better to Spousal Loss: Men or Women?

Although widowhood is much more likely to befall women than men, both genders face distinctive challenges as they cope with a partner's death. An estimated 40% to 70% of older widowed people experience a period of 2 weeks or more marked by feelings of sadness immediately after the loss. Gender differences in emotional distress following late-life widowhood have been researched extensively, yet results remain inconclusive.

Researchers agree that gender differences in psychological health in general need to be taken into consideration before one can conclude that widows or widowers fare systematically worse. Women have higher rates of depression than men; most studies estimate that women's rates of depressive disorders are between 50% and 100% higher than men's. In contrast, men have significantly higher rates of alcohol and drug dependence and antisocial behavior disorders than women. Studies that compare only widowed women and men may find that widows are more depressed, but cannot necessarily attribute this gender difference to the event of widowhood. Gender differences in psychological reactions to the loss of one's partner may be understated (or overstated) in studies that do not control the pathway variables that may account for the observed gender gap. The key pathways that link bereavement to psychological adjustment reflect gendered patterns of social interaction over the life course, characteristics of the late marriage or long-term relationship, and the context of the partner's death.

Understanding Gender Differences in Bereavement Experience

"His" and "Her" Marriage

Adjustment to spousal loss is inextricably linked to the social roles one held both within and outside of marriage. Feminist writings, exemplified by the work of sociologist Jesse Bernard, have argued that traditional marriages—where men specialize in the breadwinner role and women are responsible for childbearing and childrearing—benefit women much less than men. Marriage brings men health, power, and life satisfaction, but the institution subjects women to stress, dissatisfaction, and the loss of self. According to this perspective, women are purported to suffer less when a marriage ends because they have less to lose. However, recent empirical studies counter that marriage benefits *both* men and women, yet in different ways. Women typically benefit economically, whereas men receive richer social and psychological rewards. These gendered patterns of advantage and disadvantage within marriage provide a framework for understanding gender differences in adjustment to spousal loss.

Economic Issues

One of the most widely documented sources of distress among widows is economic strain. Widows are more likely than widowers to experience economic hardship. Although age-based income assistance programs, such as Social Security, provide economic support for older widowed people, the bereaved remain significantly worse off than their married peers. Widowed people are more likely to live below the poverty line than their married counterparts, and they tend to cyclically re-enter poverty after losing their partner. Costs associated with the funeral, medical and long-term care, or estate-related legal proceedings can devastate the fixed income of older adults. For younger women, remarriage may be a pathway out of poverty, yet demographic constraints make this option difficult for most older women.

Widows' economic disadvantage reflects lifelong patterns of gendered inequality. In traditional marriages, wives tended to childrearing and family responsibilities, while husbands were responsible for supporting the family financially. As a result, older women have had fewer years of paid work experience than their male peers. Women's accumulated pension and Social Security benefits based on their own earnings are typically much lower than those based on their husband's lifetime earnings. Moreover, the pension benefits and Social Security income of their husband may not be available or may be reduced after his death. Older widows who try to re-enter the labor force may also lack the experience to secure a good job, or they may face age discrimination.

These financial stressors, in turn, are an important source of psychological strain. Stressful life events, such as widowhood, may cast off a chain of secondary stressors that have either direct or combined effects on the survivor's well-being. Financial strain is a risk factor for depression. Bereaved women who lack expertise or experience in paying bills and making major financial or legal decisions may face considerable anxiety when forced to assume sole responsibility for the financial management of the household.

Social and Instrumental Support

In traditional marriages, women typically provide emotional, social, instrumental, and health-promoting

support to their husbands. As a result, men often have difficulty in managing household tasks, maintaining their own health, and seeking out alternative sources of emotional support after their wives have died. For these reasons, men are more likely than women to experience physical health declines, increased disability, and heightened risk of mortality after their wives die. While popular lore claims that these men may "die of a broken heart," research shows that it is the loss of a helpmate and caretaker that is really the culprit. Wives typically monitor their husbands' diets, encourage them to exercise, remind them to take their daily medications, and urge them to give up their vices, like smoking and drinking. When their wives die, these healthy reminders slip away. Widowers are more likely than married men to die of accidents, alcohol-related deaths, lung cancer, and chronic ischemic heart disease during the first six months after their loss, but not from other causes that are less closely linked to health behaviors.

Even worse for men is that their wives often are their primary (or only) source of social support and integration. Current cohorts of older men, often raised to be strong and silent, have few close friends with whom they can share their private concerns. Wives often are the family "kinkeeper"—the one who arranges dinner parties with friends and organizes outings with the grandchildren; when a man loses his wife, he also loses his connection to his social networks. Social support is essential for maintaining physical and emotional health, especially in later life.

In contrast, women's richer sources of social support over the life course are an important resource as they adjust to the loss of their husbands. Widows typically receive more instrumental and emotional support from their children than do widowers, given mothers' closer relationships with their children throughout the life course. Women also are more likely to have larger and more varied friendship networks than men, and these friendships provide an important source of support to women as they cope with their loss. These patterns reflect lifelong processes of gender-role socialization (particularly in current cohorts of older adults), where women are raised to develop close and intimate interpersonal relationships, and men are socialized to be self-reliant and independent, with few close confidants other than their spouse.

Other Influences on Widows' and Widowers' Experiences

Marital Quality

The extent to which widows and widowers mourn the loss of their late spouse also is linked to the emotional climate of the late marriage. Early research, guided by the psychoanalytic tradition, suggested that people with the most troubled marriages suffered heightened and delayed grief following their spouse's death. This perspective held that people who had conflicted or ambivalent marital relationships find it hard to let go of their spouses, yet feel angry at the deceased for abandoning them; as a result, they experienced elevated grief. Recent research shows, conversely, that people in conflicted marriages mourn less for their spouses, while people with the most loving marriages grieve most upon their loss.

The Nature of the Late Partner's Death

Late life loss is distinct from earlier losses in that it typically occurs at the end of a long chronic illness, and intensive caregiving is often required during the ailing person's final weeks. The timing of and conditions surrounding a partner's death have implications for the psychological adjustment of the bereaved spouse. On one hand, the knowledge that one's partner is going to die in the imminent future provides the couple with the time to address unresolved emotional, financial, and practical issues before the actual death. This preparation for death is believed to enable a smoother transition to widowhood. However, long-anticipated deaths due to chronic illness may be accompanied by potentially stressful experiences, such as difficult caregiving duties, financial strains imposed by long-term care, emotional isolation from other family members and friends, and neglect of one's own health symptoms.

The conditions of a spouse's death can affect women and men in different ways. For widows, sudden spousal deaths are associated with greater psychological distress, while widowers mourn most for their wives when they died after a prolonged illness. These relationships reflect gendered patterns of socialization and social interaction. Men typically have fewer sources of social support than do women and may become even more

emotionally bonded to their wives during their final weeks. Men also may have few same-sex peers who are caring for a dying spouse, and thus have few sources of peer support and advice. Women, in contrast, may rely on their female friends' direct experiences with spousal illness to prepare them for the difficult dying process and thereafter.

Partner Death Among Gays and Lesbians

Researchers know little about how older gays and lesbians adjust to the loss of their long-term life partners. This lack of research reflects the fact that no official statistics are available for same-sex unions, given the lack of social and legal approval for these relationships. Older homosexuals may face both unique challenges and advantages as they cope with loss.

Bereaved gays and lesbians may encounter conflict with their deceased partner's family, particularly with respect to the dispersion of personal possessions following death. Legal rights extended to heterosexual married couples are not typically available for same-sex couples, including the opportunity to make health care and end-of-life decisions for ill partners. Bereaved same-sex partners may not receive sufficient emotional support upon loss because the end of homosexual relationships may not be recognized or acknowledged in the wider community.

However, gays and lesbians have some resources that may enable better coping with partner loss. They may create their own support networks of friends and selected family members. They also may be more likely than their heterosexual peers to enact flexible gender roles throughout the life course. Because they are not bound to traditional gender types and family roles, they may be better prepared to manage the daily challenges and responsibilities faced by the newly bereaved.

Future Trends and Research Directions

The research presented thus far provides a detailed portrait of older widows and widowers in the United States in the late 20th and early 21st century. However, this research describes late life spousal loss as it is currently experienced, and not how it may be for future cohorts of widows and widowers. Current cohorts of older adults were born in the early 20th century, and many conformed to rigid gender type marital roles as they formed families in the mid-20th century.

Future generations of older adults, by contrast, will have educational, family, and career histories that are different from those of past generations. Current generations of young adult women have higher levels of education, more years of work experience, and higher personal earnings than do earlier cohorts of older women. As a result, they may be less dependent on their husbands for income, as well as for support with traditionally "male" type household tasks, such as home repair or financial management tasks. Likewise, each cohort of men is more likely than their father's generation to participate in homemaking and childrearing tasks. As the boundaries demarcating traditional gender roles in marriage blur, widows and widowers will likely face fewer challenges (and less anxiety) as they manage homemaking, home maintenance, and financial management tasks after their spouse dies.

At the same time, adaptation to spousal loss may become more difficult for future cohorts of widows and widowers. Two important demographic trends—increasing divorce rates and declining fertility rates—may have important consequences for how the bereaved adjust to loss. While past generations of older adults often stayed in difficult marriages because of cultural or religious prohibitions against divorce, more recent cohorts of spouses can freely divorce if their marriages are unsatisfying. If men and women dissolve their troubled marriages, then those who remain married until late life may have particularly warm and close relationships, and may be the most grief stricken upon their loss. Declining fertility rates mean that older adults will have fewer children upon whom they can rely for social support following spousal death.

As life expectancy continues to increase, the nature, cause, and trajectories of death will change; the context of death has important implications for older adults and their soon-to-be bereaved spouses. For example, medical advancements that extend the length of life may create the need for more intensive spousal caregiving, a task that typically falls to women. If the duration and intensity of late-life caregiving increases, and if wives continue to bear the burden for personal care, then cohorts of women entering old age in the future may face a more difficult adjustment to spousal loss. Further exploration of the way that social,

cultural, and technological forces shape the bereavement experience will provide knowledge of practical and political importance for future generations of bereaved spouses.

Deborah Carr

See also Adulthood and Death; Bereavement, Grief, and Mourning; Good Death; Mortality Rates, U.S.

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WITCHES

References to witches are found in a variety of historical and cultural accounts. Witches are thought to be involved in witchcraft, an activity that involves the manipulation or deciphering of supernatural forces. Witches do good things, such as defending against evil spirits, bringing prosperity, casting good spells, and healing. Witches also are believed to engage in evil activities, sometimes using their power to achieve questionable and bad goals, such as concocting love potions, casting spells, or contacting the dead. One illustration is the practice of voodoo, wherein a priest or priestess can revive the dead, who may, in turn, evolve into a zombie, that is, a revived corpse without a soul. Lacking a soul and free will, the zombie is thus controlled by the priest or priestess. This belief has apparently impacted modern folklore, found especially in horror movies, which developed this theme and created an image of mindless, flesh-eating monsters.

Within the Western European tradition, the connection between death and witches is identified in two related main themes: necromancy and the pact with the devil. Necromancy is historical and is easily traceable to biblical passages. The most famous biblical account is focused on King Saul and a visitation to the Witch of Endor before the final battle in which the king lost his life (Samuel 1:28). King Saul was an antiwitch activist, and his seeking the help of the Witch of Endor to conjure the result of the next day's battle can be considered a major social infraction. Still, the Witch of Endor managed to animate the spirit of the Prophet Samuel from the dead and, after complaining that his rest was disturbed, he gives King Saul the terrible prophecy. This biblical account highlights an important aspect of the witch: the power to control. Within this context, the Witch of Endor forced the appearance of Samuel against his wish. In this case, a necromancer witch could thus use witchcraft to force the dead to appear before the living and obey their wishes. The fact that the Witch of Endor was portrayed as a woman serves as an important omen. Within ancient Jewish law, the view and attitude toward practicing witches is found in the divine command, "Thou shalt not suffer a witch to live" (Exodus 22:10).

This historical conception attributes a special and powerful position to witches vis-à-vis that of deities. The witches' knowledge of how to cast a spell and to produce charms and potions enables them to force various deities into action that they would not have otherwise undertaken, including a special power to engage dead deities. During the Greco-Roman period, witches were thought to consult with the dead about future events.

The Pact

The Old Testament of the Bible provides an account of the fall of Satan, noting that the angel's leader Semjaza (also known as Azazel) and his followers bound themselves together by oath on Mount Hermon and descended to earth where they took wives and begat giants. The lustful and cruel deeds of these angels wrought such destruction and wickedness that God sent a huge flood (referred to as "the deluge") to cleanse the earth. And so, Semjaza and his band were sentenced to be buried under mountains until the Day of Judgment, when they were to be forever cast into the abyss of fire.

Once the existence of Satan was created and associated with evil and death, the stage was set for the next, much later stage, or what became known as the "pact." The principle upon which the pact is based was to emerge during the European witch craze of the 1400s to 1600s and the infamous Salem, Massachusetts, witch trials that would eventually hold sway in contemporary popular culture.

Emerging during the European witch hunts of the 15th to 17th centuries, the concept of the pact was to transform the public perception of witches from engaging in practices that generated social good as well as bad purposes into a completely evil entities. During a historical period in which unattached women became the primary targets of a clergy dedicated to reestablishing the supreme position of the Church in the lives of the lay population, witches became socially redefined as having lost their ability to do good because they had, in turn, become sexually dominated by Satan.

One of the most influential 15th century documents that addressed witchcraft was the 1480s *Malleus Maleficarum* or "The Witch's Hammer," which explained that only Satan could satisfy the insatiable sexual appetite of women. The religious-driven conception of the relationship between demonology and witchcraft was based on the religious argument that the world served as a battlefield upon which an ongoing struggle between Satan and God was portrayed. The social fear was that Satan might win this battle and turn the world into hell. Thus, the ongoing battle was a "battle for the souls," based on the assumption that after death the soul will either go to heaven or to hell. Heresy evidence, a major element during the dominance of the European witch craze, was that Satan recruited servants, mostly women, by signing a pact with them and turned them into his sexual subordinates. The social perception was that the pact again provided female witches the opportunity to commit evil deeds. In turn, the souls of these women belonged to the devil, and these women would serve in hell upon their death.

The main expression of the witches-pact-death connection became known as the Black Sabbath. On this day, it was believed witches, riding on broomsticks, would descend upon a cemetery where they would pay homage to Satan and his devils (frequently in the form of a stinking goat) and reaffirm the pact with the Devil.

The modern popular version of the pact stipulates that while signers may be offered wealth, good health, and power, they will not necessarily become witches, but they will certainly lose their souls to Satan when they die. This contemporary weakened correlation between witches and death is found in modern music pieces, books, and movies, such as *The Devil and Daniel Webster* (by S. Benet and movies 1941 and 2004), *Constantine* (2005), *Faust* (by J. Goethe), or TV series such as *Reaper* or *The Collector*.

Nachman Ben-Yehuda

See also Devil; Eschatology; Necromancy; Soul; Zombies, Revenants, Vampires, and Reanimated Corpses

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Wrongful Death

On the civil side of the American legal system, there are three general types of monetary compensation in the wrongful death of a person: One is noneconomic losses, or the fear, anxiety, pain, suffering, and loss of enjoyment of life of deceased prior to death. The second is the economic losses suffered by the deceased, the deceased's estate, or survivors, including medical bills, funeral expenses, lost income, and the economic value of lost services. A third is "grief and sorrow," or "grief and bereavement"—mental and emotional suffering, not of the deceased, but rather the emotional distress, grief, and sorrow to a class of people related to the victim. Some states allow such compensation to all family members, including siblings; other states restrict the "protected group" to parents and children. Despite the cold harshness of such laws, some states still deny anyone damages for grief and sorrow of a loved one. Often such grief is costly to survivors, who must undergo counseling and medical treatment for emotional distress and passing through the six stages of grief—denial, anger, bargaining, depression, guilt, and acceptance.

Wrongful death actions in some states may describe two separate and distinct legal claims. One concept is antemortem damages caused to the deceased before death (often called a survivorship claim); the other claim is for losses suffered by the estate or survivors of the deceased (technically called a wrongful death claim). To understand these concepts, it is helpful to understand some history behind the law of wrongful death and survivorship.

Wrongful Death Law in Early English Legal History

Ironically, the Anglo-American civil law of wrongful death actions has now come full circle. What in old medieval England was accepted as a right, and what 19th-century English and American courts ruled to have no legal basis, is now in 21st-century American legislatures and courts again recognized as a private right to recover damages for a fatal wrong committed on another.

In Anglo-Saxon England, a homicide in any form was regarded as a "tort," a civil offense, or a private wrong. To prevent private retaliation or family feuds and to encourage some form of peaceful resolutions, damages for killing a person were payable to the deceased's relatives. In medieval Anglo-Saxon law, this punitive reparation, termed *bot, wer,* or *wergild* ("man's-price" or "man-payment"), was paid by the wrongdoer to the kinsman of the decedent. At first, the amount of payment was set by a kind of arbitration; later, a scale of payments was established based on the social rank of the decedent. As society's attitude toward homicide changed, so did its legal remedies. Homicide was no longer viewed as a wrong to the decedent's survivors but rather as an offense against the state. By the 13th century Year Books (medieval English law reports), the evolution for redressing wrongful death was complete—every homicide became a criminal offence. Accidental and involuntary homicide were not classed as felonies, nor was the killer subject to capital punishment. As in most felonies, the defendant's property was forfeited to the state. Such killings were called "homicides *per infortunium*" and were not crimes but "misfortunes."

No private action by survivors was allowed at this early stage of English jurisprudence, partly because homicide per infortunium involved the forfeiture of the prisoner's goods. The "merger doctrine," which says a tort is merged into a crime, probably derives from this situation. Therefore, if the defendant's goods belonged to the Crown, it was useless to attempt to obtain them.

The acknowledged origin of the court-made or common law rule denying a right of recovery for the death of any person killed by the wrongful act of another derives from the 1808 dictum (i.e., expressions in a court's written opinion that go beyond the facts and do not directly apply to the facts or issues in that case and are therefore the personal views of the author and not binding on subsequent courts) of Lord Ellenborough in *Baker v. Bolton* (1808). In that case, the plaintiff's wife was fatally injured in a stagecoach accident and died 1 month later. Plaintiff sued the stagecoach owner, claiming he had "been deprived of the comfort, fellowship, and assistance of his said wife, and had from thence hitherto suffered and undergone great grief, vexation, and anguish of mind."

At trial, Lord Ellenborough instructed the jury that only damages for plaintiff's loss of society and grief could be awarded, and limited to the one-month period between the accident and his wife's death. As stated, in his infamous dictum: "In a civil court, the death of a human being could not be complained of as an injury."

Unfortunately, the illogic and unfairness of the *Baker* case was accepted by the American courts. The case was a statement of law without foundation in precedent or reason. But, like any bad precedent, subsequent judges adopting the rule advanced rationalizations for the refusal to recognize any civil cause of action for wrongful death. For example, some courts argued it was inconsistent with public policy to permit the value of human life to be subject to judicial computation or that recognition of a wrongful death action would result in the opening of a "floodgate," "numberless actions" for damage of an "awful magnitude."

These Victorian arguments lose much force when it is realized that they were advanced after the 1846 passage of Lord Campbell's Act in England, which created a right of action for wrongful death. The rationalizations for the "rule" of *Baker v. Bolton* have received much criticism. Adverse comment on this common law rule denying the right to recover for wrongful death may be found in numerous decisions and from legal scholars. The most likely reason for adoption of "the English Rule" in America is simply that it had the blessing of age. The U.S. Supreme Court has many telling answers to the old make-weight arguments about the difficulty and repugnance in valuing human life.

In *Moragne v. States Marine Lines, Inc.* (1970), the U.S. Supreme Court unanimously made one of the most important death case holdings in American jurisprudence. *Moragne* allowed a widow to assert wrongful death claims based on unseaworthiness for her husband-longshoreman's death that occurred while he was working aboard the ship owner's vessel within Florida's navigable waters. The Florida courts had held that the Florida death statute did not allow recovery for unseaworthiness. But, the Supreme Court overruled these courts, refusing to follow the common-law rule that no civil action lies for an injury resulting in death.

Although *Moragne* is important for maritime law, it is more important in the evolution in jurisprudence for rejecting the validity of *Baker v. Bolton*. The Supreme Court clearly and unequivocally ruled that there was no basis for adopting the *Baker* doctrine in the United States, and that the doctrine had been discarded even in England. Having put to rest the misconception that no common law right to sue for wrongful death existed, the Supreme Court went on to write a new nonstatutory remedy for wrongful death in maritime law.

The First Wrongful Death Act: Lord Campbell's Act

As a result of the general rule announced in *Baker v. Bolton* that "in a civil court the death of a human being could not be complained of as an injury," it was actually cheaper for a defendant wrongdoer to kill a plaintiff than to injure him. Furthermore, a victim's family was left without recourse. This injustice was remedied by England with the Fatal Accidents Act of 1846, also called Lord Campbell's Act. Titled "an Act for compensating the Families of Persons killed by accidents," it provided that whenever the death of any person is caused by the wrongful act of another, in such a manner as would have entitled the party injured to have sued had death not ensued, an action may be maintained after death in the name of his or her executor or administrator for the benefit of certain relatives. These include the spouse, parent, and child. The jury is allowed to award such damages as it may think resulted to the respective persons for whose benefit the action is brought; these damages are divided among beneficiaries in such shares as the jury by its verdict may direct. Lord Campbell's Act created a new cause of action based on a defendant's wrongful act, limited recovery to certain beneficiaries, and measured damages with respect to the loss suffered by these beneficiaries.

Wrongful Death Law in America

Building on Lord Campbell's Act, the first wrongful death statute in the United States was enacted in New York in 1847. Presently, statutes in every state create a right to recover for wrongful death. Many statutes substantially embody Lord Campbell's Act and create a right of action for losses suffered by statutorily designated beneficiaries as a result of the death. Others may be broadly classified as statutes under which death damages are measured by the loss occasioned to the decedent's estate by the death.

An important historical note is that most of the states that follow the 1846 Lord Campbell's Act unfortunately followed its "economic" damages approach. That is, most statutes were passed before or during the Industrial Revolution, at a time of child labor; almost every child in an American family was expected to earn income for the parents. Therefore, a child's death had an economic impact on the family's productivity: The loss

would usually result in an economic hardship for parents who not only lost a loved one but a productive farmhand or shop or factory worker. But if no immediate family member was "economically dependent" on the deceased, some wrongful death statutes provided no recovery for any survivors.

The language in the death statutes of each American jurisdiction varies widely. Each has different constructions or interpretations by respective courts regarding the persons for whose benefits an action may be brought, and the measure, elements, and distribution of damages. Additionally, many states have laws covering special situations, and several statutory wrongful death actions have been created under federal law. Each state has some statutory system for wrongful death damages.

The Survival or Survivorship Claim

Conceptually, a survival statute is different from a wrongful death act. Each provides a remedy for a different loss. Wrongful death acts compensate either the survivors or deceased's estate for losses they sustain. Survival statutes, on the other hand, permit recovery by the decedent's personal representative, generally on behalf of the estate—subject to certain exceptions where recovery is on behalf of the spouse, children, parents, dependent next of kin, and so on—for damages that the decedent could have recovered had he or she lived. Although originating in and caused by the same wrongful act, the cause of action that "survives" by statute is for the wrong to the injured person; the wrongful death action, under the usual Lord Campbell's Act type of death statute, addresses the wrong to the beneficiaries.

The elements of damages recoverable under survival statutes are generally as follows: conscious pain and suffering; medical, funeral and burial expenses; and loss of earnings, usually from the time of injury to the time of death. In some cases, damages are allowed for the loss of prospective economic benefit to the estate measured by the prospective net lifetime earnings discounted to present value. In some jurisdictions, punitive damages, compensatory damages for mental anguish or any outrage to the feelings of the injured person, fear, anxiety, and emotional distress prior to any injury may also be recovered. The majority of jurisdictions allow damages for a decedent's conscious pain and suffering prior to death under survival statutes and the hybrid type of survival-wrongful death statutes.

Wrongful Death Acts That Address Losses to Survivors

Lord Campbell's Act is the best example of this system of wrongful death law recovery for the benefit of survivors. This type of legal cause of action is for the protection of the survivor's "interest in the nature of an expectancy," and for the "exclusive benefit of the named beneficiaries."

However, a serious, recurring problem arises with the wrongful death of a child who is not employed and making no present monetary contributions to anyone. When the earning capacity of children becomes a realized fact, the children usually have become independent and are supporting their own families. From a pure economic viewpoint, a child today is probably a net liability to parents. The human loss to any parent from the death of a child is inexplicably great, but when examined in the cold calculations of Lord Campbell's "pecuniary loss," it is not pecuniary. Nevertheless, most courts do permit an award of damages for the parents' loss of a child as a result of wrongful conduct, and some state statutes wisely make specific provision for recovery of damages for a child's death.

Some courts allow damages for the lost inheritance or the diminution of inheritance caused by death in an amount the beneficiary would probably have received from the decedent by will or intestacy. If proven, this is considered "a pecuniary loss." Some courts, under Lord Campbell's Act statutes, allow damages for the "economic value" of the loss of advice, counsel, help, instruction, and guidance that were reasonably expected by the beneficiaries from the decedent.

Wrongful Death Acts That Address Losses to the Estate

In some states, the loss to the estate of a deceased is still measured, even where there are no surviving dependents. That is, the deceased's lifetime earnings are recoverable for the estate, even though the deceased was not financially supporting any family members.

Under the theory of these statutes, expenses incurred by the deceased before death are not included in any damages because these statutes redress the injury caused by the death. These statutes, like those patterned after Lord Campbell's Act, usually allow no damages for the deceased's

premorbid anxiety, fear, pain, and suffering, nor for the survivors' grief, sorrow, and emotional distress.

Conclusion

Death and civil damages for death are subject to rules and laws peculiar to the individual statutes and interpreting case law of the specific jurisdiction. In a general sense, recent laws and decisions over the past 100 years seem to be moving in the direction of allowing recovery of intangible losses and the protection and legal recognition of the grief and bereavement of survivors.

Beginning in the 1980s, the American civil justice system and tort laws, including wrongful death laws, came under vigorous and vitriolic attack by so-called "tort reformers." Special interest rhetoric claimed the rising cost of liability insurance was putting doctors out of business, keeping Girl Scouts from selling cookies, and preventing drug companies from producing new and valuable products for the public good. Unfortunately for victims of neglect and recklessness, the public's perception and reality often differ.

Some "tort reform" measures eliminated or altered "joint and several liability." That is, at common law if two or more defendants were each liable for conduct that legally caused a plaintiff's injury or death, then the plaintiff had the option to collect the full assessed damages from any one or all defendants. Some states eliminated or altered the "collateral source rule." Any benefits paid for medical bills or other out-of-pocket losses to a plaintiff are deducted from awarded damages, unless such benefits are from insurance that has a right to subrogate; in some cases, the insurance premiums paid by a plaintiff can still be recovered as damages. Relevant to our discussion of civil remedies for death, it is important to recognize that some tort reform laws in some jurisdictions have the effect of limiting the amount of recovery for survivors and victims of wrongful death.

Except for those states with statutory limits on nonpecuniary losses, none of the 50 states has any limits on pecuniary loss caused by wrongful death. Just as the law has expanded the remedies for injuries to emotional interests, the vast majority of jurisdictions now allow recovery for lost companionship, society, or consortium suffered by survivors of a wrongful death.

Deciding on a course of legal action to take after the death of a loved one may seem unsympathetic and calculating; however, the perishable rights, future needs, and the well-being of the deceased's family and survivors are important and time-sensitive considerations. Naturally the grieving process takes time and help from loved ones and close friends. Civil laws that may help replace, punish, and retrieve the decedent's wrongful loss have short time limits. Statutes of limitation within which a lawsuit must be filed or tort claims notices filed with known or suspected wrongdoers usually begin with the date of death. Therefore, in a compassionate and expeditious manner, some regard must be given to civil laws and methods of compensating wrongful death.

Thomas J. Vesper

See also Economic Evaluation of a Life; Grief, Bereavement, and Mourning in Cross-Cultural Perspective; Language of Death

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Zombies, Revenants, Vampires, and Reanimated Corpses

The general names given to the undead are zombies, revenants, vampires, and reanimated corpses. The undead are either *corporeal undead* or *corporeal living dead*. The corporeal undead include those animated undead who are commonly called revenants and vampires who have transformed while being undead. Zombies are the corporeal living dead. According to outward appearances, the corporeal living dead appear dead and are close to death (their senses are numbed and body functions reduced), but they are actually alive and cognizant of their surroundings.

Overview

The plea by parents to their children to "hush or you'll wake the dead" continues the ancient and culturally pervasive entrenched fear that a human body could actually return to the land of the living. When a person dies, we wish it was not true and that we could see that person again; but a fear can also exist that if that individual did rise from the dead, he or she might be malevolent. Would a person see that individual as a spirit or ghost, or would that individual rise from the grave as a decayed corpse? The fear of the presence of a moving, tangible, dead person that could be touched and could physically touch you has created the undead monsters that cultures throughout the world not only fear but also place in modern popular culture.

People from various cultures visualize the walking dead differently. Appearances of the walking dead include that they can ooze and be bloody with maggots crawling, they can lumber and stumble around, or they can fly and travel at fast speeds. They are usually visualized as being soulless also.

Zombies

Zombies are seen as individuals who look as if they are dead, but they are in fact living. It is in the Haitian community and the Vodoun (voodoo) faith where zombies are prominent and legitimately feared. The word zombie has traveled from Africa to Haiti and most likely came from the Kongo word *nzambi,* which translates somewhat into "spirit of a dead person." The process of zombification involves essentially being poisoned by a blend of substances made into a powder that might include as ingredients ground-up human remains, botanical dissociatives, and a neurotoxin (tetrodotoxin) from either the porcupine fish (*Diodon hystrix* L. and *Diodon holacanthus* L.), the puffer fish (*Sphoeroides testudineus* L. and *Sphoeroides spengleri* Bloch), and/or the Marine toad (*Bufo marinus* L.). One poison concoction could include toxic fish that are sun dried, heated, and placed in a mortar with roasted tarantula, nonvenomous lizards, parts of the brown and white toad, and ground-up human bones. The *bokor,* who makes the poison, covers his body with oil and wraps hemp sacks around him. He plugs his nostrils and covers his head with a hat to prevent from being affected. As the poison starts

its work, a person feels the sensation of tiny bugs crawling under the skin. A small amount of the powder mixture eaten in food or delivered by the prick of a thorn or directly into a wound makes a victim unable to move or speak, but they are conscious of their surroundings. The nervous system's motor responses are paralyzed. The mouth will not open and the eyes do not react to stimulus. It is possible to die of this type of poisoning because the heart rate and body temperature drop and breathing is markedly slowed and can result in asphyxiation. If the victim recovers, they fully recall their time as a zombie.

Zombie powders are administered by a *houngan* (good priest and healer) or a *bokor* (evil sorcerer). Both individuals are able to do the zombification on a victim and both are able to create an antidote. The good priest is able to create a zombie as revenge for a malevolent zombification or for placing other evil curses on a good victim. Conversely, the malevolent sorcerer creates a zombie to hold power over someone and, by not administering an antidote, could make a victim weak and subsequently die. Antidotes are mixed locally and vary from one region of Haiti to another, some requiring 30 or more ingredients, including leaves of medicinal plants such as aloe (*Aloe vera* L.), guaiac (*Guaiacum officinale* L.), and *cadaver gaté* (cf. *Capparis* sp.), mixed with odds and ends such as rock salt, mothballs, ground match heads, and sulfur powder. Scientists indicate that the tetrodotoxins have no known antidote. Some individuals believe that salt may be a key ingredient in the return of a zombie to the living because tetrodotoxins block sodium ion channels in nerve cell membranes. The bokor believe the return to the living is due to magic.

Three kinds of zombies are thought to exist. A *zombi astral* (also known as *zombi efface*) is created by an individual who comes to possess a victim's soul and alters a portion of that victim's soul. Those zombies that do make it back to the land of the living are *zombi savanne*. A *zombi cadaver* (also known as *zombi jardin*) is a creation that will be doomed to servitude to some master or its creator. These are the type of zombies that are found in the movies of popular culture, such as *White Zombies* (1933), *I Walked With a Zombie* (1943), *Zombies of the Stratosphere* (1953), *Night of the Living Dead* (1968), *Dawn of the Dead* (1978), *Chopper Chicks in Zombietown* (1991), *Boy Eats Girl* (2005), and *I Am Legend* (2007).

Revenants

A revenant is a person who was not well liked in life, was murdered or dies, and then is malevolent to the living when he returns from the dead. The revenant either goes after those who murdered him or pesters the living as an animated corpse. In folklore, the revenant is prominent in Western Europe. The French give us the verb root word *revenir,* which means to come back. Many of the accounts of revenants come from the Middle Ages during the 11th to 13th centuries. William of Newburgh wrote about many cases of revenants in the 12th century. He recounted that upon his return, a revenant filled the air with a foul stench and in his travels spread a deadly plague among the living. An English abbot of Burton in the 12th century also recounted a tale of two revenants. Two peasants who had run away from their lord died and were buried. They rose from the dead the same day and lugged their coffins with them around their village. They spoke to the villagers, warning them to leave. The villagers were stricken with disease and died immediately. The only true way of getting rid of these revenants was to dig up their corpses, cut their heads off, and burn or remove their hearts. Vampires are exterminated in a similar manner, but some folklorists say that vampires were a creation of Eastern European folklore, while the revenant comes from Western European folklore. Many anthropologists and folklorists assert that revenant is a generic term for the undead.

Vampires

Vampires are historically evil. They are the malevolent undead whose bodies rise to feed on living humans and, when necessary, animals. Vampires need to kill and feed in order to resurrect and transform into the living dead, and that necessary feeding will quench the thirst or stave off the hunger for only so long. Then the vampire must kill and feed again.

The vampire is a cross-cultural phenomenon and is not just the Dracula creation spawned by the mind of Bram Stoker, who was influenced by the horrific deeds of Vlad the Impaler. People

from many different cultures believe in a type of vampire creature and have created close to 100 different names for it. For example, vampires are known as: *loogaroo* (Haiti), *yara-ma-yha-who* (Australian Aborigines), *bluatsauger* (Germany), *vipir* (Bulgaria), *vrykolakas* (Greece), *rakshasas* (India), *langsuyar* (Malaysia), *kappa* (Japan), and the *chiang-shih* (China).

Peter Plogojowitz

There are many stories about how someone becomes a vampire. One of the most famous involves Peter Plogojowitz, who lived during the 1700s. The man called Peter died and was soon buried. The village that he lived in went through some hard times and was stricken with misfortune about 10 weeks after Peter died. An epidemic of some type made nine people sick and each died within a day. All nine were dead within 1 week. Several of those who were about to die blamed Peter Plogojowitz, indicating that he had come back from the dead and had physically lain on them and choked them while they were sleeping. The villagers were scared and felt they would only truly know if Peter was causing the deaths if they exhumed his remains and saw certain signs that would indicate that he was a vampire. They believed he would be a vampire if his body looked as if he were alive, if his hair and nails were longer, and if his body looked fatter, the latter evidence for his having feasted on the living. The villagers exhumed the body. Peter's hair and nails had grown. His old skin had been replaced by youthful skin. There was blood present in his mouth indicating his last meal on the living. The villagers took a sharpened wooden stake and drove it into his heart. Blood gushed from the heart, nose, and ears. The villagers had prevented the vampire from future malevolent activities.

Decomposition and the Vampire

The fear generated by the vampire comes from a pervasive dread of death and what happens to the body after one dies. The physical appearance of the vampire in lore and legend derives from unfamiliarity with the processes of decomposition. Currently, we know that a body goes through five stages of decomposition. It is the first three stages before skeletonization that figure into the vampire legend. During the first stage, human remains give off little odor and no color or skin changes can be seen. But unseen bacteria are working to decompose the tissue. The second stage is characterized by skin color changes on the corpse. Pink, white to gray, green, and brown colors can be seen on the fingers, ears, and nose. Eventually, parts of the arms and legs can turn black. The body starts to smell, and body parts bloat due to gas buildup inside the corpse, whereas other parts look as they did in life. Skin sags and hair can fall off. The third stage of decomposition is where the body emits the foulest odors, voices the creepiest sounds, and can look as if it were moving. Gases escape from the corpse, the abdominal wall caves in, and maggot masses at orifices move, drop, and crackle. The activity is furious and generates heat. Bone becomes evident, and adipocere, a breakdown of body tissues into a soapy material, develops. To the unknowing, hair and nails may appear to be growing, but they are really being shed due to decomposition. Skin sags and slips, making things appear to grow. Tissue retreats, and teeth in general and canine in specific become more prominent. Gas buildup enlarges the face, scrotum, and vulva areas, which before death may have appeared wasted away. These areas now look full of life. The sounds and the movement of the maggots make the corpse look as if it is moving in its repose. And, more importantly, fluids mixed with blood can stream from the mouth and nose, creating the appearance of an undead having recently fed on the living.

Tuberculosis and Vampires

In New England during the end of the 18th century and into the 19th century, the disease tuberculosis perpetuated the vampire myth. Individuals who died of tuberculosis often coughed up blood during their final days. Because the disease is highly contagious, family members or close friends of the deceased often came down with tuberculosis. The disease wastes away the body, draining an individual of energy, and they eventually started coughing up blood. The presence of blood around the mouth and the wasting away of a healthy individual fed the fear that the deceased individual was coming back and feasting on the living by draining them of their life force. In one town of West Stafford, five

out of six sisters were stricken with tuberculosis. It was firmly believed that the undead were coming back and feasting on the sisters until they died. To halt the demise of a doomed sister or relatives of the sisters, an exhumation of the five deceased sisters was performed at night and their heart and lungs were burned. It was felt that the heart and lungs kept some spark of life after death, and these needed to be destroyed. Once these organs were destroyed, the living could resume their good health.

The Vampire in Popular Culture

Lord Byron and John Polidori were two 19th-century writers who brought the vampire into popular culture through a case of literary theft. Lord Byron wrote the novel about a Greek vampire who is known in some literary circles as Augustus Darvell. John Polidori was Byron's doctor who took Byron's idea and wrote *The Vampyre,* which was published in 1819. Thus through this publication, the vampire began its rise into everyday life. Plays, operas, and musicals were written featuring vampires. Stories and novels continued to be written about vampires, such as *Varney the Vampire* (1847), *Carmilla* (1872), and of course *Dracula* (1897).

There is no monster in popular literature today that has spawned more novels than the vampire. A resurgence and steadily increasing proliferation of vampire literature began with works such as *Salem's Lot* (1976), *Interview With a Vampire* (1977), and *Hotel Transylvania* (1979). Because of these publications, vampires are everywhere in books and comics. They are housewives and crime fighters. They meet Sherlock Holmes, the Hardy Boys, and Nancy Drew. They are rabbits (*Bunnicula*), and they are ducks (*Count Duckula*). Vampires have remained a favorite monster at the box office. Many vampire movies have been made all over the world since the early two-minute film by George Méliès called *The Haunted Castle* (1896), *Nosferatu* (1922) directed by Murnau, and *Dracula* (1931) with Bela Lugosi.

Reanimated Corpses

It was Mary Shelley who brought the reanimated corpse into popular view with her novel *Frankenstein* (1818). Her story came at a time when people in England and America were becoming aware of the practice of robbing graves. Not only were corpses being mugged for valued possessions, but also body parts and whole bodies were being snatched. Body fat was being taken to make candles. Cadaver teeth, especially incisors and canines, which were easier to extract from the front of the mouth of a corpse, were valuable during the early 1800s, as they were used to make false teeth. Corpses were even stolen for ransom. Also during the 1800s corpses were stolen for medical purposes, such as providing a body for anatomical dissection. All the elements were present for Mary Shelley's monster, including the idea of how a snatched corpse could come back to life and how is it done.

Ancient Egyptian Mummy Reanimation

One of the most popular cultural monster characters is the mummy who is brought back from the dead. Many ancient Egyptian mummies have been uncovered in the sands of Egypt, indicating a population preoccupied with death. Their lives were centered on the preparations for death and the afterlife. The Egyptians loved life and wanted to carry this passion into the afterlife. A newly deceased individual would be mourned for 70 days. It was during this time that the process of embalming the corpse would take place. Corpses were dried using a natural salt called natron. Organs were removed and placed in jars to be used in the afterlife, and the body was softened and plumped up to look as lifelike as possible and then wrapped in linens. During the mourning period, an attempt was made to reanimate some of the organs and senses of the body through a ceremony called the "Opening of the Mouth." During the ritual, either the mummy itself or a statue of the individual would be touched by special tools in areas such as the mouth and eyes. After the symbolic touch of the eyes and mouth, those senses would revive; reanimation had begun. The corpse could now see, breathe, eat, drink, and more importantly, speak. It was necessary for the corpse to be able to speak words that would allow him to enter the afterlife. Family members would bring meals to the corpse and speak to the corpse during the mourning period.

Modern Reanimated Corpses

Some people want their corpse frozen after death so that in the future, when the pathological condition

that caused their demise can be reversed along with the process of death, their corpse can be reanimated. The idea of cryopreservation of humans is credited to Robert Ettinger, who founded the Cryonics Institute. The first person to be frozen for future reanimation was James Bedford, who died of lung cancer in 1967. Soon after death, his body was prepared by heparin infusions to prevent clotting of blood and a heart-lung machine kept nutrients and oxygen flowing to the brain while the body was packed in ice. Bedford's body was wrapped and placed in a cryogenic capsule that was filled with liquid nitrogen at a temperature of –320°F.

In some instances only the head is frozen because of the belief that in the future the rest of the body can be regrown. Although the corpses presently sustained through the cryonics process may not be reanimated in the future, scientists could benefit from research conducted on corpses with low to nonexistent decomposition.

Keith Jacobi

See also Ancient Egyptian Beliefs and Traditions; Egyptian Perceptions of Death in Antiquity; *Frankenstein;* Mummies of Ancient Egypt

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Appendix A

Death-Related Websites

AARP Grief and Loss: www.aarp.org/families/grief_loss

Comprehensive source of information designed to help bereaved adults of all ages.

Albert Ellis Institute: www.rebt.org

The Albert Ellis Institute (AEI), a world-renowned psychotherapy institute, is committed to advancing emotional well-being through the study and application of effective, short-term therapy with long-term results. AEI coordinates research and provides continuing education for mental health professionals, self-help workshops for the public, and affordable psychotherapy for adults, couples, children, families and groups.

All Serial Killers Dot Com: www.allserialkillers.com

Site about serial homicide.

Alternative Solutions in Long Term Care: www.activitytherapy.com/directory/html/gp21.html

This link directory provides the names of sites for Episcopal health care chaplains, palliative care, schools of pastoral psychotherapy, grief networks, family care organizations, and various other networks that provide insights for assisting the dying.

Alzheimer's Association: www.alz.org

A comprehensive site for those who desire information about Alzheimer's disease and dementia.

Alzheimer's Disease Education & Referral Center: www.alzheimers.org

This Alzheimer's Disease Education and Referral Center website will assist one to find current, comprehensive Alzheimer's disease information and resources from the National Institute on Aging

American Academy of Child and Adolescent Psychiatry: www.aacap.org

American Academy of Family Physicians: www.aafp.org

American Academy of Neurology (AAN): www.aan.com

American Association for Therapeutic Humor: www.aath.org

American Association of Homes and Services for the Aging: www.aahsa.org

American Association of Pastoral Counselors: www.aapc.org

American Association of Suicidology: www.suicidology.org

American Board of Hospice and Palliative Medicine (ABHPM): www.abhpm.org

American Counseling Association: www.counseling.org

American Family Physician: www.aafp.org

American Foundation for Suicide Prevention: www.afsp.org

American Medical Association: www.ama-assn.org

American Medical Informatics Association: www.amia.org

American Psychiatric Association—Ethics Information: www.apa.org/ethics

American Psychiatric Nurses Association: www.apna.org

American Psychoanalytic Association: www.apsa.org

American Psychoanalytic Foundation: www.cyberpsych.org/apf/index.html

American Psychological Association: www.apa.org

American Psychological Society: www.psychological science.org

Americans for Better Care of the Dying (ABCD): www.abcd-caring.org

American Society of Psychosocial & Behavioral Oncology/AIDS (ASPBOA): www.ipos-aspboa-org

Angel Babies Forever Loved: www.angels4ever.com

A nonmedical site that provides peer support but not professional opinion.

Angel Children, Legacies: www.angelchild.com

A site for survivors to express themselves by sharing their stories online.

Angels in Heaven Ministries: www.angelsin heaven.org

Angels in Heaven Ministries is a nonprofit, nondenominational, Christ-centered ministry dedicated to sharing the hope of Jesus Christ with families who have suffered the loss of a loved one, particularly that of a child.

Association for the Advancement of Gestalt Therapy: www.aagt.org

Association of Black Psychologists: www.abpsi.org

Australian Grief Link: www.grieflink.asn.au

An information resource on death-related grief for the community and professionals.

Baby Center: www.babycenter.com

Information on pregnancy and infancy.

Baby Life Line: www.babylifeline.com

A British organization that strives as its mission to "ensure the best possible outcome for mother and baby" by funding research, equipment and skills training where it is needed most in pre- and post-natal care.

Babyloss: www.babyloss.com

Bereaved Families of Ontario: www.bereaved families.net

Bereaved Families Online: www.bereavedfamilies.net

Bereaved Moms Share: http://members.aol.com/ BrvdMomShr/index.html

Bereavement Services (RTS): www.bereavement programs.com

Bereavement Training and Consultation: The Sturbridge Group: www.sturbridgegroup.com

Born Angels, Pregnancy Loss Support Group: www.bornangels.com

British Medical Journal: www.bmj.com

Canadian Funeral Directory: www.thefuneral directory.com

Cancer Care: www.cancercare.org

CancerNet: www.ncc.go.jp/cnet.html

Case Index: http://path.upmc.edu/cases

Pictures and descriptions of disease, submitted by doctors.

Causes of Death: www.benbest.com/lifeext/ causes.html

Celestis, Inc. (Space Service): www.celestis.com

With more than 20 years of experience in commercial space launches, the experienced professionals at Space Services are committed to

providing outstanding service, and to carrying on the tradition of honoring loved ones through post-cremation Memorial Spaceflights.

The Center for Multiple Birth Loss: www.multiplebirth.com/Loss/bereavem1.htm

Center to Advance Palliative Care: www.capcmssm.org

C.G. Jung Home Page: www.cgjungpage.org

The Jung Page is dedicated to exploring questions of meaning which engage the individual as well as the varied cultures in which we live. The site has original essays, reprinted articles, reviews of books and films, research tools, a lexicon of terms, and works of creativity. One can also connect with the worldwide Jungian community, including information on publishers, local societies and professional organizations, scholars, analysts, and other interested individuals.

Children's Hospice International: www.chionline.org

Children with AIDS project: www.aidskids.org

Choice in Dying: www.choices.org

Organization provides information to patients interested in active and passive euthanasia.

Christian Prayers for the Dying: www.coredcs.com/~sbro/hpdying.htm

A number of comforting prayers for the terminally ill.

CLIMB (Center for Loss in Multiple Births): www.climb-support.org

Clinicians' Yellow Pages: http://mentalhelp.net/cyp

Compassion & Choices: www.compassionandchoices.org

Nonprofit organization working to improve care and expand choice at the end of life.

Compassion Connection: www.compassionconnection.org/index.cfm

Offering the gift of compassion and concern and the ministry of presence.

Compassion in Dying: www.compassionindying.org

Creative Arts Group Psychotherapy: www.artswire.org/asgpp/tak4.htm

Crisis, Grief, and Healing: www.webhealing.com

Dead Rock Stars: http://users.efortress.com/doc-rock/deadrock.html

List of dead rock stars, dead people associated with rock, and dead people whose music helped influence and create rock.

Death and Dying: www.death-dying.com

Includes references for probate, wills, living wills, and powers of attorney.

Death in America: www.deathinamerica.com

An overview of the cultural and philosophical evolution on the subject of illness and death over the last 4 centuries of American history.

Death in the Works of Shakespeare: http://library.thinkquest.org/16665/shakey.htm

DeathNET: www.rights.org/deathnet/open.html

Education for Physicians on End-of-Life Care (EPEC): www.epec.net

End of Life Issues: www.nlm.nih.gov/medlineplus/endoflifeissues.html

A resource on issues regarding end-of-life decisions.

End-of-life Nursing Education Consortium: www.aacn.nche.edu/elnec

Ethical Wills: www.ethicalwill.com

Ethics Updates—Punishment and the Death Penalty: http://ethics.sandiego.edu/Applied/DeathPenalty/index.asp

Multimedia resources on punishment and the death penalty.

Find a Grave: www.seeing-stars.com/Buried2/HollywoodMemorial4.shtml

This website enables you to locate, and in some cases view, the final resting places of many famous international and American dead people.

Find-a-Therapist.com: www.find-a-therapist.com

Search through Find-a-Therapist's directory of verified therapists, psychologists, marriage and family counselors, social workers, licensed professional counselors, and psychiatrists.

The Five Wishes: www.agingwithdignity.org/5wishes.html

The Five Wishes document helps you express how you want to be treated if you are seriously ill and unable to speak for yourself.

Funeral and Memorial Societies of America: www.funerals.org/famsa

Funeral Consumers Alliance: www.funerals.org

This website is like a Consumer's Report for the funeral industry.

Gold Star Wives: www.Goldstarwives.org/index.html

Offers support and assistance to military widows.

The Graduate Theological Foundation: www.gtfeducation.org

Grandparent grief: http://home.att.net/~laurlev/gpgrief.html

Green Burial Council: www.greenburialcouncil.org

A group working to make burial sustainable for the planet, meaningful for the families, and economically viable for the provider.

Grief Healing: www.griefhealing.com

To help make sense out of what you may be feeling, to prepare you for what to expect in grief.

GriefNet: www.griefnet.org

Internet community of persons dealing with grief, death, and major loss.

Grief support: www.counselingforloss.com

Growth House: www.growthhouse.org

Online community for end-of-life care.

GROWW: www.groww.com

Support for sudden losses.

Hannah's Prayer: www.hannah.org

Infertility, pregnancy loss, neonatal loss.

Hollywood Forever: www.seeing-stars.com/Buried2/HollywoodMemorial4.shtml

Description of burial places of Hollywood stars.

Houston House: www.radix.net/~tangsolo/gallery/hhospice.htm

Offers, regardless of ability to pay, the highest quality of care for patients with life-threatening illnesses, through an interdisciplinary team of professionals and volunteers.

Interactive Bereavement Courses: www.bereavement.orindex.html

International Cemetery and Funeral Association: www.icfa.org/consumer.html

Internet Cremation Society: www.cremation.com

Journey of Hearts: www.journeyofhearts.org

For physicians and others who have experienced a loss.

Kings College Centre for Education About Death and Bereavement: www.deathed.ca

A listing of death-related academic courses offered in that institution's offerings.

Lamenting Sons: http://members.tripod.com/~LifeGard/index-f.html

For grieving fathers.

Last Acts: www.lastacts.org

In 2005, Last Acts—a highly acclaimed Robert Wood Johnson Foundation national

program—came to a close. The program's website, www.lastacts.org, ceased publication at the same time. Last Acts created a wealth of useful web content—for health care consumers, health care practitioners, policy-makers and employers. The site presents a selection of Last Acts editorial content. The articles are presented primarily for their historical interest, to illustrate the depth of the foundation's long commitment to quality end-of-life care. Many of the articles remain current, although some of the information could be dated.

Life Center Northwest Donor Network: www.lcnw.org

Living with Loss Foundation: www.livingwithloss.org

Loss in Multiple Birth Outreach: www.geocities.com/Heartland/7479/limlst.html

Military Executions: www.deathpenaltyinfo.org/executions-military

Information on military executions.

Murder victims: www.murdervictims.com

National Center for Death Education: www.mountida.edu

National Coalition of Homicide Survivors, Inc.: www.mivictims.org/nchs

National Funeral Directors Association: www.nfda.com

National Hospice and Palliative Care Organization: www.nho.org

National Institute of Mental Health: www.nimh.nih.gov

National Library of Medicine: www.medlineplus.gov

24-hour health information.

National Mental Health Association: www.nmha.org

National Mental Health Consumers Self-Help Clearinghouse: www.mhselfhelp.org

National Stillbirth Society: www.stillnomore.org

Noah's Window: www.noahbenshea.com/noahwindow.htm

Provides comfort and assistance regarding death and dying and the loss of loved ones.

Office for Victims of Crime (U.S. Dept. of Justice): www.ojp.usdoi.gov/ovc

Physicians Who Care: www.pwc.org

Pen-Parents: http://pages.prodigy.com/NV/fgck08a/PenParents.html

People Living With Cancer: www.plwc.org

Raindrop: http://iul.com/raindrop/index.htm?%20

An online book explaining death to children by Terry Beard.

Remembrance Wreath: www.remembrancewreath.com

The Requiem Web: http://members.optusnet.com.au/~charles57/Requiem

A site about requiems, a special type of music written for a mass on All Saints Day.

Research on Spiritual Beliefs and the Dying Process: www.ncf.org/reports_health.html

The Robert Wood Johnson Foundation Last Acts: www.lastacts.org

SANDS (Stillbirth and neonatal death support): www.vicnet.net.au/~sands/sands.html

SAVE (Suicide Awareness/Voices of Education): www.save.org

ShareGrief: www.sharegrief.com

Since the launch of ShareGrief.com in July 2001, the team of volunteer grief specialists has reached out to hundreds of people across the world who experience the death of a child, spouse, parent, sibling, friend, or other family member. Whether the loss is as a result of an accident, illness, suicide, trauma, or sudden death, the team quickly responds with support and compassion. ShareGrief offers information on support groups,

local resources, and reading materials that may be helpful to the bereaved.

Society for Military Widows: http://military widows.org

Offers support and assistance to military widows.

Sociology of Death: www.interport.netmkearl/ death.html

SOFT (Support Organization for Trisomy 18, 13, and other disorders) http://pages.prodigy.com/ NC/soft.html

Stephen Ministries: www.christcare.com

Stephen ministers will provide direct one-to-one care to troubled individuals who are coping with issues concerning dying, death, or bereavement.

Subsequent Pregnancy after Loss Support: www.spals.com

Suicide Machine: www.freep.com/suicide

Covers the controversial actions of Jack Kevorkian in the state of Michigan by providing stories of his patients.

Tragedy Assistance for Survivors, Inc.: www.taps.org

Offers assistance in meeting the long and short-term needs of military family survivors.

U.S. Living Will Registry: www.uslivingwill registry.com

Resources for preparing and registering advanced directives.

Victim Assistance: www.vaonline.org

Webhealing.com: http://webhealing.com

Webhealing.com was the Internet's first interactive grief website and has served the bereaved on the net since 1995. It offers grief discussion boards where men and women can discuss issues related to grief and healing or browse recommended grief books. The site's originator, Tom Golden, LCSW, is an internationally known psychotherapist, author, and speaker on the topic of healing from loss. There is access to excerpts from Golden's book, information on his private practice, and his columns on grief. The site also offers grief articles, grief links, and the Internet's first memorial page.

WhiteLight customized caskets: www.artcaskets .com

WidowNet: www.fortnet.org/widownet

Wills and Estate Planning: www.nolo.com/ ChunkEP/EP.index.htm

Wings: www.wingsgrief.org

An information website for caregivers and the bereaved.

Zen Hospice Project: www.zenhospice.org

Information on confronting life-threatening illness and the Buddhist approach to death and dying.

Appendix B

Death-Related Organizations

This listing includes a broad spectrum of organizations and Internet resources related to death and dying. When the purpose of an organization or website is not immediately obvious by its title, a brief description follows. Because organizations move, merge, and disband, we have listed telephone and fax numbers when known.

AARP Grief and Loss Programs (Widowed Persons Service)
601 E Street NW, Washington, DC 20049
866-797-2277 (Toll-Free)
www.griefandloss.org
Long-established program, advocate and service provider for older adults.

Abramson Center For Jewish Life (formerly known as the Philadelphia Geriatric Center)
1425 Horsham Road, North Wales, PA 19454
215-371-3000 or 888-791-5075;
Fax: 215-371-3032
Researches issues in aging and loss.

ADEC (Association for Death Education and Counseling)
111 Deer Lake Road, Suite 100, Deerfield, IL 60015
847-509-0403
www.adec.org
An international program dedicated to dying, death and bereavement through research, education, advocacy, and client support. Has a respected certification program for professionals, resource and people services, web resources, and an annual conference with national and international keynoters, myriad workshops and papers, and bookstore.

Agency for Healthcare Research and Quality (AHRQ)
540 Gaither Road, Rockville, MD 20850
301-427-1364
www.ahrq.gov
A U.S. Department of Health and Human Services agency, the AHRQ is the lead federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans. As one of 12 agencies within the Department of Health and Human Services, AHRQ supports health services research that will improve the quality of health care and promote evidence-based decision-making.

AIDS Action
1730 M Street NW, Washington, DC 20036
202-530-8030; Fax: 202-530-8031
The National Voice on AIDS, advocating responsible federal policy for improved HIV/AIDS care and services, medical research, and prevention.

AIDS Information Network
1211 Chestnut Street, 7th Floor, Philadelphia, PA 19107
215-575-1110, Ext. 131
A center for printed and other resources, networking and support.

AIDS Resource Foundation for Children
77 Academy Street, Newark, NJ 07102
973-643-0400 Fax: 973-643-4854
Provides cost-effective, family-centered services to children with HIV/AIDS.

Al-Anon; Alateen
888-425-2666
A key life-saving phone number for people struggling with addiction and those who suffer due to the addictions of others.

Alive Alone
c/o Kay Bevington, 1112 Champaign Drive,
Van Wert, OH 45891
alivalon@bright.net
Assists bereaved parents that lost an only child or all of their children. Alive Alone is an organization for education and charitable purposes to benefit bereaved parents, whose only child or all children are deceased, by providing a self-help network and publications to promote communication and healing, to assist in resolving their grief, and a means to reinvest their lives for a positive future.

Alliance for Cannabis Therapeutics
P.O. Box 21210, Kalorama Station,
Washington, DC 20009
http://marijuana-as-medicine.org
An information center and advocate for alternative therapies.

Alliance of Grandparents, A Support in Tragedy (AGAST)/MISS Foundation
P.O. Box 5333, Peoria, AZ 85385-5333
888-455-6477
info@missfoundation.org
Dedicated to assisting all grandparents when a grandchild dies. AGAST has operated since 1993 as an all-volunteer organization dedicated to helping grandparents through the trauma, stress, and grief after the loss of a grandchild. In 2007 the organization merged with the MISS Foundation, another group of compassionate volunteers, mostly bereaved parents, who serve the bereaved grandparent community. Although the MISS Foundation's focus is on pregnancy, infant, and toddler loss, the MISS Foundation's Alliance of Grandparents, A Support in Tragedy will continue to support bereaved grandparents through any grandchild loss, no matter what the age or circumstances.

Alzheimer's Association
919 N. Michigan Avenue, Suite 1000,
Chicago, IL 60611
800-272-3900
www.alz.org
National voluntary health organization supporting Alzheimer's research and care.

The American Academy of Forensic Sciences
410 North 21st Street, Colorado Springs,
CO 80904
719-636-1100; Fax: 719-636-1993
www.aafs.org
The American Academy of Forensic Sciences is a multi-disciplinary professional organization that provides leadership to advance science and its application to the legal system. The objectives of the academy are to promote education, foster research, improve practice, and encourage collaboration in the forensic sciences.

American Association for Marriage and Family Therapy (AAMFT)
1133 15th Street NW, Suite 300, Washington,
DC 20005
202-452-0109
www.aamft.org
Professional organization providing member support, resources, networking, and certification.

American Association of Suicidology (AAS)
4201 Connecticut Avenue NW, Suite 310,
Washington, DC 20008
202-237-2280
www.suicidology.org
AAS is a membership organization for all those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services. Founded in 1968 by Edwin S. Shneidman, Ph.D., AAS promotes research, public awareness programs, public education, and training for professionals and

volunteers. In addition, AAS serves as a national clearinghouse for information on suicide. The membership of AAS includes mental health and public health professionals, researchers, suicide prevention and crisis intervention centers, school districts, crisis center volunteers, survivors of suicide, and a variety of lay persons who have an interest in suicide prevention.

American Bar Association
321 N. Clark Street, Chicago, IL 60654-7598
800-285-2221
www.abanet.org/public.html

The Public Resources section of the American Bar Association website: From there people can search for information about personal planning, such as financial wills, living wills, durable powers of attorney for health care, etc., as well as societal issues such as the death penalty and physician-assisted suicide.

American Cancer Society
1599 Clifton Road NE, Atlanta, GA 30329-4251
800-ACS-2345

The definitive voice on cancer care and comfort, training, professional support, and comfort care.

American Cryonics Society
P.O. Box 1509, Cupertino, CA 95015
800-523-2001
http://americancryonics.org

The American Cryonics Society was founded in 1969 and offers several types of cold storage, post-death suspension that typically involve liquid nitrogen. Initially known as the Bay Area Cryonics Society (BACS), the organization officially changed its name in 1985 and is the oldest cryonics suspension society in the world. The website offers information on the history of cryonics, the procedure of post death suspension, and information on various suspension options and pricing.

American Ex-Prisoners of War
#40, 3201 E. Pioneer Parkway, Arlington, TX 76010
817-649-3398
www.ax-pow.com

American Foundation for AIDS Research
Suite 406, 1150 17th Street NW, Washington, DC 20036
202-331-8600 or 800-392-6327;
Fax: 202-331-8606

Fund-raising organization for AIDS research.

American Foundation for Suicide Prevention (AFSP)
120 Wall Street, 22nd Floor, New York, NY 10005
212-363-3500 or 800-273-8255; Crisis Line-
Fax: 212-363-6237
www.afsp.org

AFSP is dedicated to advancing our knowledge of suicide and our ability to prevent it. AFSP's activities include supporting research projects, providing information and education about suicide and depression, and supporting programs for suicide survivor treatment, research, and education.

American Geriatrics Society
Suite 801, 350 Fifth Avenue, New York, NY 10118
212-308-1414; Fax: 212-832-8646

Focuses on concerns and issues related to aging and the aged.

American Heart Association
7272 Greenville Avenue, Dallas, TX 75231
800-AHA-USA1
www.americanheart.org

The voice on heart disease, a major killer in America.

American Lung Association
1740 Broadway, New York, NY 10019-4374
212-315-8700

A friend to those who suffer from pulmonary disease and for loved ones grieving loved ones who died from lung disease.

American Medical Association
515 North State Street, Chicago, IL 60610
312-464-5000 or 800-621-8335;
Fax: 312-464-5600

American Society of Law, Medicine, and Ethics (ASLME)
765 Commonwealth Avenue, Suite 1634, Boston, MA 02215
617-262-4990
www.aslme.org
As medical care and dying become more challenged, ASLME has resources to address ethical issues.

American Society on Aging
833 Market, Suite 511, San Francisco, CA 94103
415-974-9600
www.asaging.org/alt_index.html
Training, professional development, resources and programs related to the needs and care of older adults.

American Sudden Infant Death Syndrome Institute
6065 Roswell Road, Suite 875, Atlanta, GA 30328
800-232-7437
www.sids.org
A needed voice for those who lose a child to SIDS.

American Trauma Society
7611 South Osborne Road, Suite 202, Upper Marlboro, MD 20772
301-574-4300 or 800-556-7890; Fax: 301-574-4301
www.amtrauma.org
Nonprofit organization devoted to injury prevention and safety issues.

Amnesty International
1 Easton Street, London WC1X 0DW, UK
+44-20-74135500
www.amnesty.org
Amnesty International is a worldwide organization with over 2 million members that is concerned to expose and address human rights abuses internationally. Amnesty International was founded in 1961 and has bureaus in 80 countries. Amnesty International is especially concerned to highlight human rights abuses, genocides, and massing killings that are orchestrated by nation-states and military regimes.

Association for Death Education and Counseling—The Thanatology Association
Suite 100, 111 Deer Lake Road, Deerfield, IL 60015
847-509-0403; Fax: 847-480-9282
Provides resources, education and certification in thanatology.

Barr-Harris Center for the Study of Separation and Loss During Childhood, The Institute for Psychoanalysis
Suite 1300, 122 South Michigan Avenue, Chicago, IL 60603
312-922-7474

Bath University Centre for Death and Society (CDAS)
c/o Caron Staley, Centre Manager, Centre for Death & Society, Department of Social & Policy Sciences, University of Bath, Bath, BA2 7AY, UK
01225-386949
cdas@bath.ac.uk
CDAS is the UK's only center devoted to the study and research of social aspects of death, dying, and bereavement. Established in September 2005, CDAS is an interdisciplinary centre of regional, national, and international importance. It provides a center for the social study of death, dying, and bereavement and acts as a catalyst and facilitator for research, education and training, policy development, media, and community awareness.

Befrienders International
26/27 Market Place, Kingston-upon-Thames, Surrey KT1 1JH, UK
www.befrienders.org
A model program throughout the United Kingdom and abroad that aims to provide support and prevent suicide.

Bereaved Families of Ontario
Watline Postal Outlet, P.O. Box 10015, Mississauga, ON L4Z 4G5, Canada
905-813-4337 or (Toll-Free) 877-826-3566; Fax: 905-813-4339
An association of families who have lost a child by death.

Bereaved Parents of the USA
P.O. Box 1394, Winter Park, FL 32789
www.bereavedparentsusa.org;
www.liseydreams.com

Aids and supports bereaved parents and families struggling to survive their grief after the death of a child. BP/USA is a national nonprofit, self-help group that offers support, understanding, compassion, and hope, especially to the newly bereaved, be they bereaved parents, grandparents, or siblings struggling to rebuild their lives after the death of their children, grandchildren, or siblings.

Bridge Builders (The World Pastoral Care Center)
c/o Dr. Richard Gilbert,
471 N. Commonwealth, Elgin, IL 60123
847-289-0234
dick.gilbert@yahoo.com

Networking (international), courses, Speakers Bureau, resources, care for professionals.

Canadian Association for Suicide Prevention
www.casp-acps.ca

The Canadian Association for Suicide Prevention is in the process of developing a Canadian blueprint of a national strategy for suicide prevention. The purpose is to articulate what a national strategy would look like that would, in turn, prompt action by all segments of Canadian society including all government levels.

The Candlelighters Childhood Cancer Foundation
National Office, P.O. Box 498, Kensington, MD 20895-0498
800-366-CCCF or 800-366-2223
staff@candlelighters.org

The Candlelighters Childhood Cancer Foundation National Office was founded in 1970 by concerned parents of children with cancer. Today, membership consists of over 50,000 members of the national office and more than 100,000 members across the country, including Candlelighters affiliate groups. The foundation's mission is to provide information and awareness for children and adolescents with cancer and their families, to advocate for their needs, and to support research so every child survives and leads a long and healthy life.

Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314
703-837-1500 or 877-658-8896 (Spanish speakers);
Fax: 703-837-1233 or 800-658-8898

A program of the National Hospice and Palliative Care Organization (NHPCO), providing support and resources including state-specific advanced directives.

Casket Manufacturers Association of America
Suite Y, 49 Sherwood Terrace, Lake Bluff, IL 60044
847-295-6630; Fax: 847-295-6647

Center for Death & Society (CDAS)
c/o Dr. Glennys Howarth, Department of Social and Policy Sciences, University of Bath, Claverton Down, Bath, BA2 7AY
UK cdas@bath.ac.uk
www.bath.ac.uk/cdas

The CDAS is the UK's only center devoted to the study and research of social aspects of death, dying, and bereavement. Established in September 2005, CDAS is an interdisciplinary center of regional, national, and international importance. It provides a center for the social study of death, dying, and bereavement and acts as a catalyst and facilitator for research, education and training, policy development, media, and community awareness. Locally and nationally, research and teaching links are being forged with health professionals, local government, charities, business, and the media. Internationally, it aims for collaborative research projects, involving visiting professors and researchers. The center also hosts the editorial office of *Mortality*, a journal promoting the interdisciplinary study of death and dying.

The Center for Loss and Life Transition
3735 Broken Bow Road, Fort Collins, CO 80526
970-226-6050
DrWolfelt@centerforloss.com

For bereaved adults and children and bereavement caregivers. The Center for Loss is dedicated

to "companioning" grieving people as they mourn transitions and losses that transform their lives. The center helps mourners by walking with them in their unique life journeys, and both professional caregivers and lay people, by serving as an educational resource and professional forum.

Center for Loss in Multiple Birth (CLIMB), Inc.
P.O. Box 91377, Anchorage, AK 99509
907-222-5321
climb@pobox.alaska.net
CLIMB, the Center for Loss in Multiple Birth, Inc., includes parents throughout the United States, Canada, Australia, New Zealand, and beyond who have experienced the death of one or both twins or higher multiples at any time from conception through birth, infancy, and childhood.

Center for the Prevention of Sexual and Domestic Violence
2400 N. 45th Street, Suite 10, Seattle, WA 98103
206-634-1903
www.cpsdv.org
Resources, training, care, and intervention for a program that can lead to a death or can emerge in bereavement.

Center for the Study of Religion/Spirituality and Health
Box 3400, Duke University Medical Center, Durham, NC 27710
919-681-6633
www.dukespiritualityandhealth.org

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road, Atlanta, GA 30333
800-CDC-INFO (800-232-4636)
Through the CDC's site, you can link to other sources of statistics, reports, and health care data.

Centers for Disease Control, Prevention Information Network (NPIN)
P.O. Box 6003, Rockville, MD 20849
800-458-5231; Fax: 888-282-7681
Collects, analyzes, and disseminates information on HIV/AIDS, TB, and other emerging diseases.

Child Death Hotline (UK)
Huntingdon House, 278-290 Huntingdon Street, Nottingham NG1 3LY, UK
0800-282-986
Serving the children and their families in the United Kingdom.

Children's Bereavement Center
Suite 307, 7600 South Red Road, South Miami, FL 33143
305-668-4902; Fax: 305-669-9110

The Compassionate Friends
P.O. Box 3696, Oak Brook, IL 60522
877-969-0010 (Toll-free) or 630-990-0010
www.compassionatefriends.org
The Compassionate Friends is about transforming the pain of grief into the elixir of hope. It takes people out of the isolation society imposes on the bereaved and lets them express their grief naturally.

The Compassionate Friends (UK)
35 North Street, Bristol BS3 1EN, UK
www.tcf.org.uk
Support programs for grieving parents and siblings.

Compassion Books
7036 State Hwy 80 South, Burnsville, NC 28714
800-970-4220; Fax: 828-675-9687
Books, audios, videos, and other resources about illness, loss, death, and grief for children and adults.

Concerns of Police Survivors (COPS)
P.O. Box 3199, South Highway 5, Camdenton, MO 65020
573-346-4911 or 800-784-COPS
cops@nationalcops.org
www.nationalcops.org
Concerns of Police Survivors, Inc. provides resources to assist in the rebuilding of the lives of surviving families and affected co-workers of law enforcement officers killed in the line of duty as determined by federal criteria. Furthermore, C.O.P.S. provides training to law enforcement agencies on survivor victimization issues and educates the public of the need to support the law enforcement profession and its survivors.

Consortium of Forensic Science Organizations (CFSO)
2535 Pilot Knob Road, Mendota Heights, MN 55120-1120
651-681-8566; Fax: 651-681-8443
www.thecfso.org

Formed in 2000, CFSO is an association of six forensic science professional organizations: American Academy of Forensic Sciences, American Society of Crime Laboratory Directors, American Society of Crime Lab Directors—Laboratory Accreditation Board, Forensic Quality Services, International Association for Identification, and National Association of Medical Examiners. These professional organizations together represent more than 12,000 forensic science professionals across the United States. The mission is to speak with a single forensic science voice in matters of mutual interest to its member organizations, to influence public policy at the national level, and to make a compelling case for greater federal funding for public crime laboratories and medical examiner offices. The primary focus of the CFSO is local, state, and national policymakers, as well as U.S. Congress. The CFSO interacts on a regular basis with the National Institute of Justice, various components of the FBI, the Technical Support Working Group, the Department of Homeland Security, and others.

Continental Association of Funeral Memorial Societies, Inc.
2001 S Street NW, Suite 530, Washington, DC 20009
202-745-0634
www.funerals.org

A body donor card to a medical research school may be obtained from this organization.

Cremation Association of North America
401 North Michigan Avenue, Chicago, IL 60611
312-245-1077; Fax: 312-321-4098

Cruse Bereavement Care
Cruse House, 126 Sheen Road, Richmond, Surrey TW9 1UR, UK

A leader in bereavement education, training, and resources serving the United Kingdom.

Day of the Dead
www.azcentral.com/ent/dead

For those seeking resources for many Latinos dealing with death and bereavement.

The Dougy Center for Grieving Children & Families
3909 SE 52nd Avenue, Portland, OR 97206
503-775-5683 or 866-775-5683
Fax: 503-777-3097
help@dougy.org
www.dougy.org; www.grievingchild.org

The Dougy Center provides support in a safe place where children, teens, young adults, and their families grieving a death can share their experiences. The Dougy Center was the first center in the United States to provide peer support groups for grieving children.

Duke University Medical Center Library
www.mclibrary.duke.edu/subject/endoflife

This site has a nice compilation of organizations with many important links for hospice, palliative care, materials for physician educators, advance directives, living wills, end-of-life organizations, and other resources for improving the care of the dying.

Durham University Centre for Death and Life Studies
www.dur.ac.uk/cdals

The UK Durham University Centre exists to foster and conduct research into life values, beliefs, and practices that relate to living and dying. It seeks to encourage and facilitate interdisciplinary approaches wherever possible among the humanities, the social and life sciences, and medicine. It also benefits from the support of Durham University's Institute of Advanced Study.

Families of Unsolved Murders
P.O. Box 159, Levittown, PA 19059
Hotline@unsolvedmurders.com
Information and support.

Five Wishes
www.agingwithdignity.org

A timely and timeless process for helping people prepare for and communicate about their dying.

Foundation of Thanatology—American Institute of Life-Threatening Illness and Loss
161 Fort Washington Avenue, New York, NY 10032
212-928-2066

Publications and seminars focusing on death education.

Fred Hutchinson Cancer Research Center
110 Fairview Avenue N., P.O. Box 19204, Seattle, WA 98109
206-667-5000

Funeral and Memorialization Information Council
13625 Bishop's Drive, Brookfield, WI 53005
262-814-1545; Fax: 262-789-6977
Promotes education and information exchange between funeral and memorial service organizations; website provides links to member death-care organizations.

Funeral Consumers Alliance
33 Patchen Road, South Burlington, VT 05403
800-458-5563
www.funerals.org
Information for consumers.

The Gay and Lesbian National Hotline
888-843-4564
Information, resource, counseling, and support.

Gerontological Society of America
Suite 901, 220 L Street NW, Washington, DC 20005
202-842-1275; Fax: 202-842-2088

Grief, Inc. (includes American Grief Academy)
13605 164th Street Court E, Puyallup, WA 98374
253-929-0649 or 888-564-6018
tony@griefinc.com
griefinc.net
Resources, programs, consultation, speakers bureau.

Griefwork Center, Inc.
c/o Barbara Rubel, P.O. Box 5104, Kendall Park, NJ 08824
732-422-0400
A specialist in health care institutions and services, PTSD, and suicide. Support, networking, and programs.

Growth House
2215-R Market Street, #199, San Francisco, CA 94114
415-863-3045
info@growthhouse.org
www.growthhouse.org
Growth House, Inc. provides this award-winning portal as an international gateway to resources for life-threatening illness and end-of-life care. Our primary mission is to improve the quality of compassionate care for people who are dying through public education and global professional collaboration. Our search engine gives you access to a comprehensive collection of reviewed resources for end-of-life care.

GROWW-Grief Recovery Online
11877 Douglas Road, #102-PMB101, Alpharetta, GA 30005
Staff@GROWW.org
GROWW is a place where peer groups in an online chatroom environment teach that you have "permission to grieve" and where you learn that the emotions you can't understand are seen in a "mirror image" of someone describing exactly what you are going through. It becomes a place where you learn that by receiving the support and understanding that helped you get through the pain of losing a loved one, you can then help someone else who is beginning the grieving process.

The Hastings Center
21 Malcolm Gordon Road, Garrison, NY 10524
845-424-4040; Fax: 845-424-4545
Programs and publications concerning issues of medical ethics.

Hemlock Society/Compassion and Choices
P.O. Box 101810, Denver, CO 80250-1810
800-247-7421; Fax: 303-639-1224
www.compassionandchoices.org
This organization is at the forefront of the right-to-die movement. It also supports things like quality pain management at the end of life, but the organization is firm in the position that euthanasia and/or physician-assisted suicide should be legal.

The site has many features including a glossary of terms relating to death and dying, end-of-life services, how to work toward improving laws in the courts, legislature and Congress, and counseling and health care services.

Hope for Bereaved
4500 Onondaga, Syracuse, NY 13219
315-475-9675
www.hopeforbereaved.com
A pioneer in bereavement care, resources, and support groups. Also doing work with workplace grief.

Hospice Association of America
228 Seventh Street SE, Washington, DC 20003
202-546-4759; Fax: 202-547-9559

Hospice Education Institute
3 Unity Square, P.O. Box 98, Machiasport, ME 04655
207-255-8800 or 800-331-1620;
Fax: 207-255-8008

The Hospice Foundation of America
1621 Connecticut Avenue, Suite 300, Washington, DC 20009
202-638-5419
www.HospiceFoundation.org
The Hospice Foundation of America provides professional and personal support for persons involved in hospice care. It offers a monthly newsletter, *Journeys: A Newsletter for the Bereaved*. Annually it offers a teleconference that is a major educational event in North America reaching over 100,000 persons, as well as a companion book. In addition, the foundation publishes other educational materials and offers a website that includes information on local hospice organizations.

Hospice International
http://hospiceinternational.com
This is an important website that has an enormous amount of information available, including an extensive list of Canadian, United States, and worldwide hospice and end-of-life organizations. One can also find caregiver resources, caregiver tools, grief and bereavement resources, and hospice/palliative care and listings for other related organizations.

HUGS (Help, Understanding, and Group Support for Hawaii's Seriously Ill Children and Their Families)
3636 Kilauea Avenue, Honolulu, HI 96816
808-732-4846; Fax: 808-732-4881

Huntington's Disease Society of America
Suite 902, 505 Eighth Avenue, New York, NY 10018
212-239-3430 or 800-345-4372;
Fax: 212-243-3430

International Anti-Euthanasia Task Force
P.O. Box 760, Steubenville, OH 43952
740-282-3810; Fax: 740-282-0769
Opposes assisted suicide and voluntary euthanasia.

International Association for Near-Death Studies
P.O. Box 502, East Windsor Hill, CT 06018
860-644-5216

International Association for Organ Donation
P.O. Box 545, Dearborn, MI 48121-0545
313-745-2379
www.iaod.org

International Association for Suicide Prevention
IASP Central Administration Office, Le Barade, F31330, Gondrin, France
33-562-29-1947; Fax: 333-562-29-1947

International Association of Pet Cemeteries
5055 R. 11, Ellenburg Depot 12935
518-594-3000

International Cemetery and Funeral Association
Suite 100, 107 Carpenter Drive, Sterling, VA 20164
703-391-8400 or 800-645-7700;
Fax: 703-391-8416

International Council of AIDS Service Organizations (ICASO)
Suite 402, 65 Wellesly Street E., Toronto, ON M4Y 1G7, Canada
416-921-0018; Fax: 416-921-9979
Network of community-based AIDS organizations; coordinates and works in partnership with key international agencies.

International Federation of Telephonic Emergency Services
Pannenwag 4, Siebengewald, The Netherlands NL-5853
31-885-21448
Facilitates exchange of information among providers of telephone help-lines in 20 countries.

International Order of the Golden Rule
P.O. Box 28689, St. Louis, MO 63146
314-209-7142 or 800-637-8030;
Fax: 314-209-1289
Association of independently owned and operated funeral homes founded in 1928; provides publications and films.

Internet Cremation Society
www.cremation.org
Provides people in the United States and Canada with an online resource for learning more about cremation and helping them locate low-cost providers in their area.

KARA
457 Kingsley Avenue, Palo Alto, CA 94301
650-321-5272; Fax: 650-473-1828
Emotional support services for people with life-threatening illness, limited life expectancy, or grief.

Leukemia and Lymphoma Society of America
Suite 520, 66 Canal Center, Alexandria, VA 22314
703-535-6650 or 800-955-4572;
Fax: 703-535-8163
Raises funds to fight leukemia by means of research, health care, and education.

London Bereavement Network
356 Holloway Road, London N7 6PA, UK
www.bereavement.org.uk

Longwood University—Doctor Assisted Suicide
http://www.longwood.edu/library/SUIC.HTM
A guide to doctor-assisted suicide websites and literature.

MADD
511 E. John Carpenter Freeway, Suite 700, Irving, TX 75062
800-438-6233
For those who need care and support after the death of loved one due to a drunk driver.

Make-A-Wish Foundation® of America
3550 North Central Avenue, Suite 300, Phoenix, AZ 85012-2127
800-722-WISH (9474); Fax: 602-279-0855
www.wish.org
The Make-A-Wish Foundation was founded in 1980 to grant wishes to children suffering from life-threatening diseases. Since its inception, the organization has helped over 167,000 children.

Medic Alert Foundation
2323 Colorado Avenue, Turlock, CA 95381
209-668-3333 or 888-633-4298;
Fax: 209-669-2450
Provides information about members' medical conditions; sells bracelets, necklaces, emblems to signify medical alert status.

The Melissa Institute for Violence Prevention and Treatment
Suite 204, 6250 Sunset Drive, Miami, FL 33143
786-662-5210; Fax: 786-662-5211
Consultation, education, and direct sponsorship of various projects relating to youth violence and firearms injury.

Monument Builders of North America
136 South Keowee Street, Dayton, OH 45402
800-233-4472; Fax: 937-222-5794

Names Project Foundation
101 Hoke Street NW, Atlanta, GA 30318
404-688-5500; Fax: 404-688-5552

NARAL (National Abortion and Reproductive Rights Action League)
Suite 700, 1156 15th Street NW, Washington, DC 20005
202-973-3000; Fax: 202-973-3096

National Abortion Federation
Suite 450, 1660 L Street NW, Washington, DC 20036
202-667-5881 or 800-772-9100 (Hotline);
Fax: 202-667-5890
Pro-choice organization.

National Association for Victim Assistance
1730 Park Road NW, Washington,
DC 20010
202-232-6682

National Association of Atomic Veterans
11214 Sageland, Houston, TX 77089
www.naav.com
NAAV provides the U.S. Atomic Veteran community to voice their concerns about their inability to get a fair hearing regarding their developing radiogenic health issues.

The National Association of Medical Examiners
NAME Headquarters, 430 Pryor Street SW, Atlanta, GA 30312
404-730-4781
http://thename.org
NAME is the national professional organization of physician medical examiners, medical death investigators, and death investigation system administrators who perform the official duties of the medicolegal investigation of deaths of public interest in the United States. NAME was founded in 1966 with the dual purposes of fostering the professional growth of physician death investigators and disseminating the professional and technical information vital to the continuing improvement of the medical investigation of violent, suspicious, and unusual deaths. Growing from a small nucleus of concerned physicians, NAME has expanded its scope to include physician medical examiners and coroners, medical death investigators, and medicolegal system administrators from throughout the United States and other countries.

National Cancer Institute
Public Inquiries Office, Building 31,
Room 10A03, 31 Center Drive, MSC 2580,
Bethesda, MD 20892
800-422-6237
www.nci.nih.gov

National Catholic Cemetery
Conference Building #3,
1400 South Wolf Road, Hillside, IL 60162
708-202-1242 or 888-850-8131;
Fax: 708-202-1255

National Catholic Ministry to the Bereaved
Box 16353, St. Louis, MO 63125
314-638-2638
ncmbereave@aol.com
www.griefwork.org
The National Catholic Ministry to the Bereaved is committed to serve all people who have experienced the death of a loved one. Its holistic care is dedicated to the spiritual support of individuals, parishes, and communities.

National Center for Death Education
Mount Ida College, 777 Dedham Street,
Newton, MA 02459
617-928-4500
Offerings include resource library and summer institute.

National Citizens' Coalition for Nursing Home Reform
Suite 801, 1828 L Street NW, Washington,
DC 20036
202-332-2275; Fax: 202-332-2949

National Coalition for Cancer Survivorship
Suite 770, 1010 Wayne Avenue, Silver Spring,
MD 20910
301-650-9127 or 888-650-9127;
Fax: 301-565-9670

National Coalition to Abolish the Death Penalty (NCADP)
1705 DeSales Street NW, Fifth Floor,
Washington, DC 20036
202-331-4090
info@ncadp.org
www.ncadp.org
The National Coalition to Abolish the Death Penalty is a national organization that was founded in 1976 in the wake of the Supreme Court Decision that permitted states to resume executions. The goal of the NCADP, and its over 100 affiliated branches across the United States, is to abolish the death penalty wherever it is administered.

National Council on Aging
4th Floor, 1901 L Street NW, Washington, DC 20036
202-479-1200; Fax: 202-479-0735

National Donor Family Council (National Kidney Foundation)
30 East 33rd Street, New York, NY 10016
800-622-9010 or 212-889-2210
www.kidney.org

The National Kidney Foundation, a major voluntary nonprofit health organization, is dedicated to preventing kidney and urinary tract diseases, improving the health and well-being of individuals and families affected by kidney disease, and increasing the availability of all organs for transplantation. Through its more than 50 local offices nationwide, the NKF provides vital patient and community services, conducts extensive public and professional education, advocates for patients through legislative action, and supports kidney research to identify new treatments.

National Fallen Firefighters Foundation
P.O. Drawer 498, Emmitsburg, MD 21727
301-447-1365
www.firehero.org

National Funeral Directors Association (NFDA)
13625 Bishops Drive, Brookfield, WI 53005
262-789-1880
www.nfda.org

National Highway Traffic Safety Administration
NHTSA Headquarters,
1200 New Jersey Avenue SE, West Building, Washington, DC 20590
888-327-4236 or 800-424-9153 (TTY);
Media inquiries: 202-366-9550
www.nhtsa.dot.gov

The National Highway Traffic Safety Administration (NHTSA) is a federal agency that is under the auspices of the Department of Transportation whose mission is to reduce vehicular crashes and prevent traffic injuries and the loss of life. The NHTSA was created in 1970 by the passage of the Highway Safety Act. The NHTSA website is a clearinghouse for safety reports and scientific studies, for informational tips meant to improve the safety of the traveling public, and a host of other statistical data related to highway safety.

National Hospice & Palliative Care Organization (NHPCO)
Suite 300, 1700 Diagonal Road, Alexandria, VA 22314
703-516-4928
www.nhpco.org

The organization's mission is to lead and mobilize social change for improved care at the end of life. The mission is to ensure that at the end of life, people have the opportunity to maintain their dignity and self-respect, live their final days pain-free, and access the highest-quality care available through hospice.

National Indian Council on Aging
10501 Montgomery Boulevard NE, Suite 210, Albuquerque, NM 87111
505-292-2001
www.nicoa.org

National Institute for Jewish Hospice
732 University Street, North Woodmere, NY 11598
800-446-4448

Association of individuals, businesses, and organizations interested in helping terminally ill Jewish persons and their families.

National Institute for Nursing Research
National Institutes of Health
31 Center Drive, Room 5B10, Bethesda, MD 20892
301-496-8230 or 866-910-3804;
Fax: 301-480-8845

National Institute on Aging
Building 31, Room 5C27, 31 Center Drive, MSC 2292, Bethesda, MD 20892
301-496-1752
Research and information.

National Institutes of Mental Health
6001 Executive Boulevard, Room 8184, MSC 9663, Bethesda, MD 20892
301-443-4513
www.nimh.nih.gov/research/suicide.htm

National Library of Medicine
8600 Rockville Pike, Bethesda, MD 20894
301-594-5983 or 888-346-3656;
Fax: 301-402-1384
www.ncbi.nlm.nih.gov/PubMed

PubMed is a project developed by the National Center for Biotechnology Information (NCBI) at the National Library of Medicine (NLM), located at the National Institutes of Health (NIH). It has been developed in conjunction with publishers of biomedical literature as a search tool for accessing literature citations and linking to full-text journals at websites of participating publishers.

National Organization for People of Color Against Suicide (NOPCAS)
www.nopcas.com
NOPCAS is committed to stopping the tragic epidemic of suicide in minority communities. The organization is developing innovative strategies to address this national problem.

National Organization for Victim Assistance (NOVA)
510 King Street, Alexandria, VA 22314
707-535-6682; Fax: 703-535-5500

National Reference Center for Bioethics Literature
Kennedy Institute of Ethics,
Georgetown University, 102 Healy Hall,
37th and O Streets NW,
Washington, DC 20057
202-687-3885 or 800-BIO-ETHX;
Fax: 202-687-6770

National Right to Life Committee
512 Tenth Street NW, Washington, DC 20004
202-626-8800

National SIDS Clearinghouse
8201 Greensboro Drive, Suite 600, McLean, VA 22102
703-821-8955

National SIDS Resource Center
Suite 601, 2115 Wisconsin Avenue,
Washington, DC 20007
202-687-7466 or 866-866-7437;
Fax: 202-784-9777

New England Center for Loss and Transition
P.O. Box 292, Guilford, CT 06437
203-458-1734
www.neclt.org

NOVA (National Organization for Victim Assistance)
1757 Park Road NW, Washington, DC 20010
202-232-6682

OncoLink University of Pennsylvania Cancer Center
3400 Spruce Street—2 Donner, Philadelphia, PA 19104
Fax: 215-349-5445
www.oncolink.com
This site contains an extensive resource directory about cancer. From specific information about particular types of cancer to psychosocial support and personal experiences, the global resources include institutions, organizations, associations, support groups, online journals, book reviews, and other resources for cancer patients and physicians.

Oncology Nursing Society
125 Enterprise Drive, Pittsburgh, PA 15275
412-859-6100 or 866-257-4667;
Fax: 412-859-6162 or 877-369-5497

Parents of Murdered Children (POMC)
100 East Eighth Street, Suite 202, Cincinnati, OH 45202
513-721-5683 or 888-818-POMC (Toll-Free);
Fax: 513-345-4489
natlpomc@aol.com
www.pomc.com
Dedicated to helping the survivors of homicide victims with supportive family services after the murder of a family member or friend. POMC makes the difference through ongoing emotional support, education, prevention, advocacy, and awareness; to provide support and assistance to all survivors of homicide victims while working to create a world free of murder.

Parents Without Partners
1650 South Dixie Highway, Suite 402,
Boca Raton, FL 33432
800-637-7974
www.parentswithoutpartners.org
The problems are many in bringing up our children alone, contending with the emotional conflicts of divorce, never-married, separation, or widowhood. PWP, Inc., is the only international organization that provides real help in the

way of discussions, professional speakers, study groups, publications, and social activities for families and adults. Through the exchange of ideas and companionship, PWP hopes to further our common welfare and the well-being of our children.

Park Ridge Center for the Study of Health, Faith, and Ethics
Suite 203, 205 West Touhy Avenue, Park Ridge, IL 60068
847-384-3504; Fax: 847-384-3557
Programs and publications concerning issues of medical ethics.

Perinatal Loss
2116 NE 18th Avenue, Portland, OR 97212
503-284-7426

Planned Parenthood Federation of America
434 West 33rd Street, New York, NY 10001
212-541-7800 or 800-798-7092;
Fax: 212-245-1845
Pro-choice organization.

Project Inform
1375 Mission Street, San Francisco, CA 94103
415-558-8669; Fax: 415-558-0684
800-822-7422 (treatment hotline)
Information clearinghouse on experimental drug treatments for persons with HIV or AIDS.

PTSD Alliance
450 West 15th Street, Suite 700, New York, NY 10011
877-507-PTSD
www.ptsdalliance.org

Robert Wood Johnson Foundation
Route 1 College Road, Princeton, NJ 08543
609-452-8701
www.rwjf.org

Rolling Thunder, Inc.
P.O. Box 216, Neshanic Station, NJ 08853
908-369-5439
www.rollingthunder1.com
Rolling Thunder is a nonprofit organization that exists to bring awareness to the issue of military personnel designated as prisoners of war (POW) and/or those that are missing in action (MIA). The organization is also concerned to highlight injustices and problems that American veterans face.

Service Corporation International
1929 Allen Parkway, Houston, TX 77019
713-522-5141
SCI is the world's largest provider of funeral and cemetery services; site provides information on arranging a funeral and grief support services.

SHARE Pregnancy & Infant Loss Support
402 Jackson, St. Charles, MO 63301-2893
800-821-6819 or 636-947-6164;
Fax: 636-947-7486
share@nationalshareoffice.com
www.nationalshareoffice.com
The mission of Share Pregnancy and Infant Loss Support, Inc., is to serve those whose lives are touched by the tragic death of a baby through early pregnancy loss, stillbirth, or in the first few months of life.

Society of Military Widows
5535 Hempstead Way, Springfield, VA 22151
703-750-1342, Ext. 3003, or 800-842-3451, Ext. 1005
pdshecter76@gmail.com
The Society of Military Widows (SMW) was founded in 1968 by Theresa (Tess) Alexander to serve the interests of women whose husbands died while on active military duty, of a service-connected illness, or during disability or regular retirement from the armed forces. SMW is a nonprofit organization chartered in the State of California under section 504 (c)(4) of the Internal Revenue Service Code.

Solace Tree
c/o Emilio Parga, P.O. Box 2944, Reno, NV 89505
775-324-7723
www.solacetree.org
Resources, training, speakers bureau.

Starbright Foundation
Suite M100, Wilshire Boulevard, Los Angeles, CA 90036
310-479-1212 or 800-315-2580;
Fax: 310-479-1235

Supports projects that empower seriously ill children and teens to deal with the challenges that accompany prolonged illness.

Suicide Information & Education Centre
#201, 1615 10th Avenue SW, Calgary, AB
T3C 0J7, Canada
403-245-3900
www.suicideinfo.ca
Suicide prevention training programs.

TAPS (Tragedy Assistance Programs for Survivors)
2001 S Street NW, Suite 300, Washington, DC 20009
800-368-TAPS
For survivors of military death.

TIHAN (Tucson Interfaith HIV/AIDS Network)
Suite 301, 1011 North Craycroft Road,
Tucson, AZ 85711
520-299-6647
Support and advocacy for people living with HIV/AIDS and their loved ones.

Today's Caregiver Magazine
3005 Greene Street Hollywood, FL 33020
954-893-0550 or 800-829-2734;
Fax: 954-893-1779

Tragedy Assistance Program for Survivors, Inc. (T.A.P.S.)
Suite 800, 910 17th Street NW, Washington, DC 20006
800-959-8277
National nonprofit organization serving families who have lost a loved one on active duty in the U.S. armed forces.

Twinless Twins Support Group International
11220 St. Joe Road, Fort Wayne, IN 46835
219-627-5414

United States Holocaust Memorial Museum
100 Raoul Wallenberg Place SW, Washington, DC 20024-2126
202-488-0400 or 202-488-0406 (TTY)
www.ushmm.org
The United States Holocaust Memorial Museum has seen more than 25 million visitors since it first opened its doors in 1993. The museum and its website are recognized as the preeminent authority for resources related to the Jewish Holocaust.

University of Toronto Joint Centre for Bioethics
88 College Street, Toronto, ON M5G 1L4, Canada
416-978-2709; Fax: 416-978-1911
Designed to be a model of interdisciplinary collaboration creating new knowledge and improving practices with respect to bioethics, this site features information about clinical ethics and serves as a resource for the media, policymakers, and community groups.

Wisconsin Grief Education Center
29205 Elm Island, Waterford, WI 53185
262-534-2904; Fax: 262-534-6039
Education, counseling, and consulting to large and small groups in and out of state.

World Health Organization
Avenue Appia 20, 1211 Geneva 27, Switzerland
+ 41-22-791-21-11;
Fax: + 41-22-791-31-11
www.who.int/en
The World Health Organization is an international body, under the auspices of the United Nations, whose primary function is to address global health problems by providing technical assistance to governments, implementing evidenced-based best practices for addressing disease and death risks, and providing surveillance of emerging mortality trends (in addition to other important services). The World Health Organization came into existence on April 7, 1948, a few years after the founding of the United Nations.

The World Pastoral Care Center
c/o Dr. Richard Gilbert,
471 N. Commonwealth, Elgin, IL 60123
847-289-0234
dck.gilbert@yahoo.com
Resources, international networking, teaching, presentations, comfort, and support.

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